Screening and Assessment of Co-Occurring Disorders in the Justice System

Screening and Assessment of Co-occurring Disorders in the Justice System

U.S. Department of Health and Human Services
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Executive Summary

This monograph examines a wide range of evidence-based practices for screening and assessment of people in the justice system who have co-occurring mental and substance use disorders (CODs). Use of evidence-based approaches for screening and assessment is likely to result in more accurate matching of offenders to treatment services and more effective treatment and supervision outcomes (Shaffer, 2011). This monograph is intended as a guide for clinicians, case managers, program and systems administrators, community supervision staff, jail and prison booking and healthcare staff, law enforcement, court personnel, researchers, and others who are interested in developing and operating effective programs for justice-involved individuals who have CODs. Key systemic and clinical challenges are discussed, as well as state-of-the art approaches for conducting screening and assessment.

The monograph also reviews a range of selected instruments for screening, assessment, and diagnosis of CODs in justice settings and provides a critical analysis of advantages, concerns, and practical implementation issues (e.g., cost, availability, training needs) for each instrument. A number of the evidence-based instruments described in this monograph are available in the public domain (i.e., are free of charge) and can be downloaded on the internet.

Not all of the instruments described in this monograph are designed for universal use in screening or assessing for both mental and substance use disorders, and some may not be suitable for use with special SRSXODWLRQV RU LQ VSHFL¿F MXVWLFH VHWWLQJV)RU H[DPSO described here are primarily designed for use with adults in the justice system, and many have not been validated for use with juveniles. Many of the assessment instruments reviewed in this monograph also require specialized training and clinical expertise to administer, score, and interpret. These considerations DUH H[SORUHG LQ PRUH GHWDLO LQ ODWHU VHFWLRQV RI WKLV

$ VLJQL¿FDQW DQG JURZLQJ QXPEHU RI SHRSOH LQ WKH MXVWLF percent of offenders have substance use disorders, and approximately 17–34 percent have serious mental illnesses—rates that greatly exceed those found in the general population (Baillargeon et al., 2010; Ditton, 1999; Lurigio, 2011; SAMHSA's GAINS Center, 2004; Peters, Kremling, Bekman, & Caudy, 2012; Steadman, Osher, Robbins, Case, & Samuels, 2009; Steadman et al., 2013). Several populations, such as juveniles, female offenders, and veterans, are entering the justice system in increased numbers and have elevated rates of CODs, including substance use, trauma, and other mental disorders (Houser, Belenko, & Brennan, 2012; Pinals et al., 2012; Seal et al., 2011). These individuals often require specialized interventions to address their CODs and staff who are familiar with their unique needs.

People with CODs present numerous challenges within the justice system. These individuals can at times exhibit greater impairment in psychosocial skills and are less likely to enter and successfully complete treatment. They are at greater risk for criminal recidivism and relapse. The justice system is generally ill-equipped to address the multiple needs of this population, and few specialized treatment programs exist in jails, prisons, or court and community corrections settings that provide integrated mental health and substance use services (Lurigio, 2011; Peters et al., 2012; Peters, LeVasseur, & Chandler, 2004).

A major concern is that the justice system does not have a built-in mechanism for personnel to identify individuals with these types of behavioral health issues, and there is all too often a failure to effectively screen and assess people with CODs who are in the justice system (Balyakina et al., 2013; Chandler,

accuracy of information compiled; implementation of risk assessment; use of evidence-based screening, assessment, and diagnostic instruments; and use of assessment information to develop and update individualized treatment/case plans. A variety of online and other types of modules are available to train staff in the screening and assessment of CODs.

Key Issues in Screening and Assessment of Co-occurring Disorders in the Justice System

Prevalence and Significance of Co-occurring Disorders in the Justice System

The number of people entering the criminal justice system has increased in the past several decades. The population under correctional supervision in the United States rose from 5.1 million adults in 1994 to a peak of 7.3 million in 2007 but has fallen each successive year (Brown, Gilliard, Snell, Stephan, & Wilson, 1996; Glaze & Kaeble, 2014). In 2013, the total correctional population fell to 6.9 million adults (Glaze & Kaeble, 2014). Approximately 2.9 percent of the U.S. adult population is currently under some form of criminal justice supervision (Glaze & Herberman, 2013). The criminalization trend in the United States resulted from changes in drug laws and law enforcement practices and from the absence of public services for people who have mental or substance use disorders, who are homeless, and who are impoverished. Mental disorders are quite elevated in criminal justice settings such as jails and prisons (Lurigio, 2011; Steadman et al., 2013). For example, individuals in prison are diagnosed with schizophrenia at much higher rates than the general population (Grella, Greenwell, Prendergast, Sacks, & Melnick, 2008; Steadman et al., 2013). Recent estimates indicate that 17–34 percent of jail inmates have a recent history of mental disorders (Steadman et al., 2009; Steadman et al., 2013), including depressive disorders, bipolar disorders, and posttraumatic stress disorder (PTSD), while approximately 3 percent of offenders have psychotic disorders (Grella et al., 2008; Steadman et al., 2013). Approximately a quarter of offenders report other disorders, such as anxiety disorders (Grella et al., 2008; Zlotnick et al., 2008), and about half report any type of mental disorder (James & Glaze, 2006). Use of conservative and more comprehensive diagnostic measures yields estimates of mental disorders that range from 10 to 15 percent of people incarcerated in jails and prisons (Steadman et al., 2013).

Rates of substance use disorders among justice-involved individuals are also substantially higher than in the general population (Lurigio, 2011; Steadman et al., 2013). Well over half of all incarcerated individuals have substance use problems (Baillargeon et al., 2010; Baillargeon et al., 2009; James & Glaze, 2006; Lurigio, 2011; Steadman et al., 2013). The lifetime prevalence of DSM-IV The lifetime prevalence of DSM-IV substance use disorders among prisoners is over 70 percent (Baillargeon et al., 2010; Baillargeon et al., 2009; Lurigio, 2011). These rates far surpass those found in the general population (Robins & Regier, 1991; Lurigio, 2011; Steadman et al., 2013). Importantly, many of these individuals report that their crimes leading to the most recent arrest were committed while using drugs or alcohol, and 86 percent of offenders report using illicit substances in their lifetime (Lurigio, 2011; Mumola & Karberg, 2006).

An increasing number of individuals in jails, prisons, and community settings have both mental and substance use disorders, or CODs, which presents numerous challenges in providing effective services (Baillargeon et al., 2010; James & Glaze 2006; Lurigio, 2011; Peters et al., 2012). Studi Ja5]TJcate that 60–87 percent of justice-involved individuals who have severe mental

- Serious medical problems
- Reduced ability to refrain from substance use
- Premature termination from treatment
- Rapid progression from initial substance use to substance use disorder
- Frequent hospitalization for mental disorders
- Housing instability or homelessness
- Poor prognosis for completion of treatment
- Temporal instability in severity of symptoms related to mental and substance use disorders
- Noncompliance with medication and treatment interventions
- High rates of depression and suicide
- Poor level of engagement and participation in treatment
- Criminal recidivism

Most comprehensive programs in justice settings provide an integrated treatment approach, consistent with evidence-based practices… (National Institute on Drug Abuse, 2006)

When released from prison, jail, or residential treatment facilities, people with CODs may not have access to the medications that stabilized them SULRU WR UHOHDVH DQG RIWHQ H[SHULHQFH GLI¿FXOWLHV engaging in community mental health and drug treatment services (Osher, Steadman, & Barr, 2002, 2003; Weisman, Lamberti, & Price, 2004). Other barriers to community integration include lack of affordable housing and transportation, barriers to accessing employment once one has a criminal record, and the termination of income supports and entitlements. Coordinating the diverse medical, mental health, substance use, and supervision needs of these individuals can be a daunting task and often requires the ability to navigate among service systems, institutions, and agencies that have very different missions, values, organizational structures, and resources (Chandler et al., 2004; Lurigio, 2011; Peters et al., 2012).

Despite these challenges, an increasing number of CODs treatment programs have been successfully implemented in justice settings (Peters et al., 2004, 2012). Most comprehensive programs in justice settings provide an integrated treatment approach,

DSM-5 have changed regarding symptomatic expression, cognitive processing, and the like. 'HWDLOHG LQIRUPDWLRQ UHJDUGLQJ FULWHULD FKDQJHV LQ '60 LV SURYLGHG LQ WKLV PRQRJUDSK. PTSD criteria is provided later in this monograph. Finally, panic and agoraphobia are now two VHSDUDWH GLVRUGHUV UDWKHU WKDQ RQH DV LQ '60 panic disorder with or without agoraphobia (APA, 2013).

Distinguishing between Co-occurring Disorders: Differential Diagnoses

A hallmark of CODs is the highly interactive nature of mental and substance use disorders and how each disorder affects the symptoms, course, and treatment of the other disorder. The American Psychiatric Association (2013) describes a number of different ways in which the two sets of disorders are interdependent and interactive:

- One disorder may predispose a person to another type of disorder
- A third type of disorder (e.g., chronic health condition, such as HIV/AIDS) may affect or elicit the onset of mental or substance use disorders
- Symptoms of each disorder may be augmented, as these often overlap between mental and substance use disorders (e.g., anxiety, depression [APA, 2013])
- Other disorders, such as borderline personality disorder (BPD, as classified by DSM-IV), may predispose individuals to more severe mental disorders such as major depressive disorder and substance use disorders
- Alcohol or other drugs may induce, or more frequently mimic or resemble, a mental disorder

As a result of the intertwined nature of mental and substance use disorders among people in the justice system, it is critically important to assess the recent and historical use of substances to determine whether there were direct effects (e.g., symptom exacerbation) that resulted from substance use. For example, it is important to determine if mental health symptoms appeared after engaging in substance use. Similarly, assessment should consider whether engaging in substance use was motivated by attempts to alleviate symptoms of mental disorders (e.g., agitation, anxiety, depression, sleep disturbance). Other strategies to ascertain an accurate diagnostic picture include establishing a temporal framework to better understand the relationship between substance use and mental health symptoms; for example, investigating the presence of mental health symptoms following periods of abstinence (either voluntary or coerced) can help determine if there is a causal relationship between the mental and substance use disorders. Similar steps during assessment should be taken to rule out mental disorders occurring due to a general medical condition.

Evidence-based screening and assessment strategies for justice-involved individuals who have CODs recognize the interactive nature of the disorders and the need for ongoing examination of the relationship between the two disorders. Attention to the interactive nature of the disorders VKRXOG EH UHÀHFWHG LQ RQJRLQJ activities and use of repeated measures to assess changes in the diagnostic picture and in symptoms and levels of impairment related to the two sets of disorders. Treatment planning, provision of clinical served to8s,d in ce0a]Dts 5.4(reatme55004800C0004 e.g.suicidical be (her)4065.6(273oxinibationg and4(rels ofunc

Importance of Screening and Assessment for Co-occurring Disorders in Justice Settings

People in the justice system with CODs differ widely in type, scope, and severity of symptoms and in complications related to their disorders. Screening and assessment provide the foundation

offender and available services. Research also indicates the importance of matching offenders to program services based on an individualized SURILH RI 3FULPLQRJHQLF QHHGV ÍFULPLQDOULVN level, and "responsivity" factors (Andrews, 2012; Andrews & Bonta, 2010a) that affect the ability of offenders to engage in evidence-based treatment and supervision—areas that are discussed in "Special Clinical Issues in Screening and Assessment for Co-occurring Disorders in the Justice System."

Several approaches for treatment matching of offenders to treatment and supervision services are described in this monograph. One model used to identify the severity of substance use and co-occurring mental disorders and to match people to treatment services is the Patient Placement Criteria (PPC), developed by the American Society of Addiction Medicine (ASAM). The ASAM PPC are used to match individuals to appropriate levels and types of treatment and have been effective as an assessment approach in the criminal justice system for people who have CODs. This model provides an assessment of six dimensions related to treatment, such as severity, frequency, and duration of substance use, in addition to other factors, including risk of relapse, co-occurring mental health symptoms, motivation and readiness for treatment, and social and occupational functioning (Mee-Lee, 2013; Stallvik & Nordahl, 2014). These factors are used to match patients to different levels of services, ranging from early intervention to medically managed intensive inpatient services and including specialized treatment programs for CODs. Research indicates that the ASAM PPC are able to triage people who have mental disorders to more intensive treatment programs geared towards CODs (Stallvik & Nordahl, 2014) and that people referred to more intensive treatment services have more severe mental health and substance use problems.

Opportunities for Screening and Assessment

Opportunities for screening and assessment are present at all points of contact within the criminal justice system. The Sequential Intercept Model (see Figure 1) provides a conceptual framework for communities to organize targeted strategies for justice-involved individuals with serious mental illness. Within the criminal justice system there are numerous intercept points—opportunities for linkage to services and for prevention of further penetration into the criminal justice system. This linear illustration of the model shows the paths an individual may take through the criminal justice V\VWHP ZKHUH WKH ¿YH LQWHUFHSW areas that communities can target for diversion, engagement, and reentry.

Intercept 1: Law Enforcement

In general, opportunities for screening at Intercept 1 are presented to law enforcement; other

Figure 1. The Sequential Intercept Model

c D G U H R I R I ¿ F H U V Z K R K D Y H
of training and are responsible for resolving calls
involving people experiencing a mental health
F U L V L V 7 K H V H R I ¿ F H U V R I W
drop-off site, and many use checklists to aid the
L G H Q W L ¿ F D W L R Q R I P H Q W D O X V H
Tracking forms and databases are used for record
N H H S L Q J D Q G L G H Q W L ¿ F D W L V

First responders, especially law enforcement
R I ¿ F H U V D U H H [S H F W H G W R I W
a manner as possible. Opportunities to train
U H V S R Q G H U V L Q W K H L G H Q W Q G
symptoms of mental and substance use disorders
and to more quickly resolve crisis situations,
whether through training in de-escalation
techniques or in the administration of naloxone to
counter a heroin overdose, have more operational
value than adding extensive screening procedures
1 H Y H U W K H O H V V O D Z H Q I R U F
document their observations and ensure that
information is provided to emergency room, crisis

stabilization unit, or mobile crisis staff. Where a hand off to a health care practitioner is not possible, information should be communicated to M D L O E R R N L Q J R U O R F N X S R I ¿ F H U V

The ability to effectively screen and assess for co-occurring disorders during a crisis also poses a challenge for crisis response staff, whether they are mental health mobile crisis clinicians or emergency room personnel. When responding to D S H U V R Q L Q F U L V L V L G H Q W L ¿ F D W L R Q R I F R R F F X U U L Q J disorders is challenging due to limited health

Court-based diversion programs, including

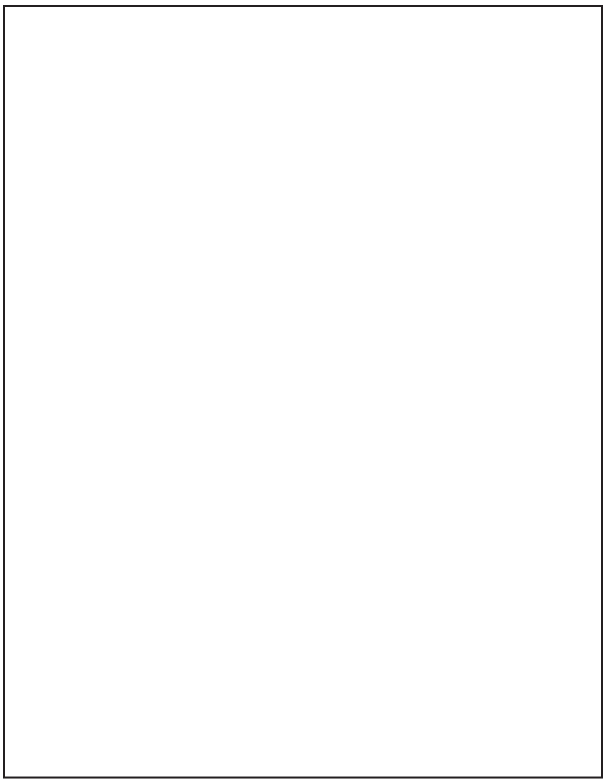

Figure 6. Intercept 5: Community

capacity to work with inmates while they are still incarcerated and for a period of time after release. As with probation agencies, prisons and parole departments are implementing risk and need assessment instruments to guide supervision and treatment programming. Information gathered from these instruments should be shared with community practitioners to better inform the treatment process.

Intercept 5: Community Corrections

Probation

The majority of people under correctional supervision are on probation. Collaboration between probation agencies and behavioral health programs are essential to reducing recidivism and promoting recovery (see Figure 6). For probation agencies, new probationers can be screened at booking for co-occurring disorders. Officers can also take advantage of information on a probationer's treatment needs that has been gathered during earlier intercepts, such as at pretrial or for the presentence investigation.

For probationers who have been diverted to a specialized program at Intercept 2 or Intercept 3, the information may be available from the agency responsible for case management. Probation officers can use this place probationers into appropriate services, such as groups, or into specialized, lower ratio caseloads, where officers have training in the supervision of people with mental or substance use disorders. Specialized probation caseloads and co-located probation and mental health services are some of the strategies being used to achieve better probation outcomes for individuals with co-occurring disorders. Comprehensive screening and assessment can match probationers to appropriate services, while criminal risk and need assessments can match them to appropriate supervision levels. Probationers who are struggling to comply with the terms of supervision may need to be screened for co-occurring disorders in order to determine

intensity of mental health, substance use, social, medical, and other problems. As a result, no single FOLQLFDO DSSURDFK ¿WV WKH QHHGV RI WKLV SRSXODWLRQ and effective and comprehensive screening and assessment procedures are of paramount LPSRUWDQFH LQ GH¿QLQJ WKH VHTXHQFH IRUPDW DQG nature of needed interventions. Screening and assessment of CODs are part of a larger process of gathering information that begins at the point of contact of the individual with the justice system. The Center for Substance Abuse Treatment's Treatment Improvement Protocol (TIP) Series #42 and other government monographs (Center for Substance Abuse Treatment [CSAT], 2005a; Steadman et al., 2013; NIDA, 2006) outline a set of sequential steps that are often followed in gathering information related to CODs. These steps provide a blueprint for developing a comprehensive system of screening and assessment activities and include the following:

- Engage the offender
- Collect collateral information (e.g., from

Screening

Screening for CODs is a brief, routine process GHVLJQHG WR LGHQWLI\ LQGLFDWRUV RU ³UHG ADJV´ IRU the presence of mental health, substance use, or RWKHU LVVXHV WKDW UHÀHFW DQ LQGLFDWLRQ QHHG IRU treatment and for alternative types of supervision or placement in housing or institutional settings. Screening may include a brief interview, use of self-report instruments, and a review of archival records. Brief self-report instruments are often used to document mental health symptoms and patterns of substance use and related psychosocial problems. Generally, screening instruments do not UHTXLUH WKDW VWDII PHPEHUV DUH OLFHQVHG FHUWLÀHG or otherwise credentialed, and minimal training is usually required to administer, score, and LQWHUSUHW ¿QGLQJV +RZHYHU VWDII WUDLQLQJ PD\ EH needed to provide effective referral to services if a screening indicates the presence of problems in a particular area (e.g., related to trauma history and current symptoms of PTSD).

In justice settings, screening for CODs should be conducted for all individuals shortly after the point of arrest and at the time of transfer to subsequent points in the system. While separate screening instruments have been developed to detect mental health and substance use issues in the justice system, until recently, few instruments were available for examining CODs. Optimally, screening tools should be well validated and reliable, with demonstrated properties in both justice and non-justice settings (Steadman et al., 2013). Screening should be conducted early in the process of compiling information, so that results can inform the need for assessment and diagnosis (Hiller et al., 2011; NIDA, 2006).

Among the goals of screening for CODs are the following:

- Detection of current mental health and substance use symptoms and behaviors
- Determination as to whether current symptoms or behaviors are influenced by CODs (e.g., trauma history)
- Examination of cognitive deficits
- Identification of criminal risk level to inform the need for placement in more or less intensive levels of treatment, supervision, and custody
- Identification of acute needs (e.g., violent behavior, suicidal ideation, severe medical problems) that may need immediate attention
- Determination of eligibility and suitability for specialized CODs treatment services
- Level of functional impairment (e.g., stress tolerance, interpersonal skills)

It is important to consider the multiple types and purposes of screening. For example, a series of screenings may be provided in jails and prisons WR DGGUHVV VHYHUDO GLIIHUHQW and risk screening is typically conducted early on to identify security issues (e.g., history of escape, past aggressive behavior within the institution) and to determine level of custody; program needs; and other issues, including history of trauma. Medical VFUHHQLQJ LGHQWL¿HV KHDOWK LV mental health status and substance use history. Mental health and substance use screenings often are also included within interviews conducted by pretrial services or other court-related agencies. In community and jail settings, presentence or postsentence investigations (PSIs) are frequently completed to assist in determining the judicial disposition or case planning. These often involve an interview and set of brief screenings to identify whether individuals are at high risk for violence or recidivism and to identify problems that may be addressed through treatment or supervision, LQFOXGLQJ VSHFL¿F PHQWDO KHDO as PTSD related to trauma. Brief screening PD\ DGGUHVV OLWHUDF\ DQG HGXFD In related areas of cognitive and behavioral LPSDLUPHQW H J LQWHUSHUVRQD stress tolerance), there are few well-validated screening tools that gather information relevant for placement and disposition. As a result, these

Assessment

Assessment of CODs is typically conducted through a clinical interview and may include psychological, laboratory, or other testing and compilation of collateral information from family, friends, and others who are in close proximity to the individual. Assessment is usually conducted by a trained professional who is either licensed or certified to provide mental health and substance use treatment services. Those conducting assessments for substance use and mental health problems would optimally have received advanced graduate level training and supervised experience in providing clinical services and have significant experience in assessing mental and substance use disorders. Assessment in the criminal justice setting should be conducted by individuals who are knowledgeable about the dynamics of criminal behavior and who understand the pathways and interactions between criminal behavior and clinical pathology related to substance use and mental disorders.

Assessment of CODs provides a comprehensive examination of psychosocial needs and problems, including the severity of mental and substance use disorders, conditions associated with the occurrence and maintenance of these disorders, problems affecting treatment, individual motivation for treatment, and areas for treatment interventions. A risk assessment is often provided that examines a range of "static" (unchanging) and "dynamic" (changeable) factors that independently contribute to the likelihood of criminal recidivism, violence, institutional misconduct, or other salient behaviors. The risk assessment process is described in more detail in "Special Clinical Issues in Screening and Assessment for Co-occurring Disorders in the Justice System." As indicated previously, assessment is an ongoing process that helps to engage justice-involved individuals in the treatment planning process, identify strengths and weaknesses, review motivation and readiness for change, examine cultural and other environmental needs, provide diagnoses related to CODs, and determine the appropriate setting and intensity and scope of services necessary to address CODs and related needs. Several multistaged models for assessing CODs are described in monographs that address both offender and non-offender populations (Mee-Lee, 2013; CSAT, 2005a; 2006a; Steadman et al., 2013).

Goals of the CODs assessment process include the following:

- Examine the scope and severity of mental and substance use disorders, conditions associated with the occurrence and maintenance of these disorders, and interactions between these disorders (e.g., history of symptoms, psychotropic medication use, collateral information)
- History of previous mental health or substance use treatment(s) and response to treatment(s)
- Family history of mental health or substance use disorders
- Development of diagnoses according to formal classification systems (e.g., DSM-5)
- Identification of the full spectrum of psychosocial problems that may need to be addressed in treatment
- Determination of the level of service needs related to mental and substance use problems
- Identification of the level of motivation and readiness for treatment
- Review of other factors that may inhibit engagement in evidence-based services for CODs, such as literacy, transportation, and history of trauma/PTSD
- Examination of individual strengths, areas of functional impairment, cultural and linguistic needs, and other environmental and social supports that are needed
- Evaluation of the risk for behavioral problems, violence, and criminal recidivism that may affect placement in various institutional or community settings
- Review of criminogenic risk factors (or "criminogenic needs"), such as antisocial attitudes and peers, educational deficits,

and presence of mental and substance use

issues are particularly important in providing differential diagnosis and in identifying the specific nature of CODs. Unfortunately, few assessment instruments examine the chronological relationship between CODs and the intertwined nature of these disorders

- Medical/health care history and status
  - Key areas to examine include history of injury and trauma, chronic disease, physical disabilities, substance toxicity and withdrawal, impaired cognition (e.g., mental status examination for severe cognitive impairment), neurological symptoms, and prior use of psychiatric medication. Assessment should also examine the presence of chronic health disorders (e.g., diabetes, heart conditions) and infectious disease (e.g., HIV/AIDS, TB, Hepatitis C)
- Criminal justice history and status
  - The complete criminal history should be reviewed, including prior arrests and reasons for arrests/incarceration, in addition to current criminal justice status
- Cultural and linguistic needs
  - Cultural beliefs about mental and substance use disorders, treatment services, and the role of treatment professionals, including potential feelings of discrimination from treatment and service practitioners and willingness to report mental health symptoms
  - A105 >>BD,pe0snapt,pe0the treatment

substance use instruments. Integrated screening and assessment approaches are associated with more favorable outcomes among people in the

- History of unstable housing or homelessness
- History of legal difficulties or incarceration
- Suicidality
- History of emergency room or acute care visits
- High frequency of relapse to substance use
- Antisocial or substance-using peers
- Poor relationships with family members
- Family history of substance use or mental disorders
- History of mental health and substance use treatment, often coupled with patterns of poor adherence to treatment
- History of disruptive behavior

Observable Signs and Symptoms of Co-occurring Disorders

In addition to the previously listed risk factors for CODs, several observable signs and symptoms of mental and substance use disorders should be reviewed during screening and assessment. These include the following:

- Unusual affect, appearance, thoughts, or speech (e.g., confusion, disorientation, rapid or slurred speech)
- Suicidal thoughts or behavior
- Paranoid ideation
- Impaired judgment and risk-taking behavior
- Drug-seeking behaviors
- Agitation or tremors
- Impaired motor skills (e.g., unsteady gait)
- Dilated or constricted pupils
- Elevated or diminished vital signs
- Hyperarousal or drowsiness
- Muscle rigidity
- Evidence of current intoxication (e.g., alcohol on breath)
-

these considerations may shape the process of conducting screening, assessment, treatment, and supervision. For example, the format of WUHDWPHQW JURXSV PD\ QHHG WR EH PRGL¿HG WR include more experiential work; repetition of material; and extensive modeling, practice, and feedback related to psychosocial skills. Third, WKHVH GH¿FLWV PD\ DIIHFW WKH RXWFRPHV RI WUHDWPHQW and supervision and should be considered in determining the intensity, duration, and scope of treatment and supervision services. Finally, these areas may become the focus of some treatment and supervision activities through interventions such as cognitive and behavioral skills training and motivational enhancement groups. Unfortunately, many of these complex areas of cognitive and behavioral functioning are not easily measured or assessed using traditional instruments. Assessment of these areas is most effectively accomplished over a period of time and through an approach that incorporates observation, interview of collateral sources, review of records, and use of specialized assessment instruments.

Other Psychosocial Areas of Interest

Assessing individual strengths and environmental supports can help to provide optimism for successful recovery, establish strategies for managing mental and substance use disorders, identify key interests and skills, and determine expectancies related to treatment (CSAT, 2005a;

In recent years, a number of key “criminal justice FKDUDFWHULVWLFV´ KDYH EHHQ LGHQWLILHG DV KLJKO\ UHOHYDQW WR VKDSLQJ WUHDWPHQW, SDUROH, DQG FDVH/WUHDWPHQW SODQQLQJ VHUYLFHV IRU MXVWLFH-involved individuals who have CODs. These individuals tend to be younger at the time RI WKHLU ¿UVW RIIHQVH DQG RIWHQ KDYH D KLVWRU\ RI aggressive or violent behavior. They also tend to have histories of multiple incarcerations and are often unable to function independently in criminal justice settings (Baillargeon et al., 2010; Castillo & Alarid, 2011; Kubiak, Essenmacher, Hanna, & Zeoli, 2011; McCabe et al., 2012; Mueser, 2005; Sindicich et al., 2014).

Criminal risk should also be carefully examined, as described in more detail in “Special Clinical Issues in Screening and Assessment for Co-occurring Disorders in the Justice System.” The most salient area of risk is for criminal recidivism, although assessment is sometimes conducted to identify risk for institutional violence, technical violations while on community supervision, and for committing sexual offenses. People in the justice system who have CODs are generally at higher risk for recidivism than other offenders (Skeem, Nicholson, & Kregg, 2008). As described later in this monograph, key areas to include in risk screening and assessment include “static” risk factors (e.g., history of prior felony arrests/ FRQYLFWLRQV DQG DJH DW ¿UVW DUUHVW ³G\QDPLF´ risk factors related to antisocial beliefs, attitudes, behaviors, and peers; substance use problems; HGXFDWLRQDO GH¿FLWV XQHPSOR\PHQW YRFDWLRQDO GH¿FLWV VRFLDO DQG IDPLO\ SUREOHPV DQG ODFN of prosocial leisure skills. Parental history of involvement in the justice system may give information about the development of antisocial personality characteristics and issues related to child development and early attachment and loss. Assessment of criminal risk can identify the severity of problems in each of these areas and the most important targets for intervention during treatment and supervision. A range of risk assessment instruments are available that can be administered at several different points in the justice system (e.g., pretrial, incarceration, reentry, community supervision).

The following criminal justice information can assist in shaping treatment, supervision, and case/treatment planning services for justice-involved individuals who have CODs:

& Curtis, 2007). Heavier drug users demonstrate more frequent and more severe criminal behavior WKDW À XFWXDWHV ZLWK WKH Hcompliance, and program completion. Positive 1996; Bennett et al., 2008; Carpenter, 2007). Decreasing substance use among justice-involved individuals through treatment and monitoring can ultimately reduce the frequency of crimes (particularly violent crimes) committed by this population. Drug testing is often used to identify and monitor substance use, abstinence, relapse, and overall treatment progress in the justice system due to limitations of self-report data (Dupont & Selavka, 2008; Kleinpeter, Brocato & Koob, 2010; Large, Smith, Sara, Paton, Kedzior, & Nielssen, 2012; Martin, 2010; Peters, Kremling, & Hunt, 2015; Rosay et al., 2007). Drug testing is preferred over other means of detecting use, such as self-report or observation of symptoms, because it increases the likelihood of detection and reduces the lag time between relapse and detection (Dupont & Selavka, 2008; Large et al., 2012; Martin, 2010).

Drug testing can be conducted at all stages of the justice system, including after arrest; before trial; and during incarceration, probation, and parole (Friedmann, Taxman, & Henderson, 2007; Kleinpeter et al., 2010; Paparozzi & Guy, 2011). Drug testing can inform judges whether conditions regarding substance use should be included in bail setting and sentencing. It can be used to ensure that an individual is meeting such requirements; for example, testing can provide information about abstinence during probation and parole supervision. Use of drug testing is particularly important in drug courts, mental health courts, and in other diversion programs that provide supervised treatment and case management services in lieu of prosecution or incarceration (Marlowe, 2003; NADCP, 2014; Paparozzi & Guy, 2011). For example, within drug courts, routine monitoring of substance use is often linked to sanctions that are established in advance and that escalate. Examples of sanctions include verbal reprimands by the judge, writing assignments, community service, and increasing intervals of detention.

When used in combination with treatment, routine drug testing can encourage treatment retention, drug tests, failure to submit to drug testing, or adulterated samples should lead to routine QRWL¿FDWLRQ RI MXGJHV VXSHUYLVRUV DQG WUHDWPHQW others who provide oversight of the individual within the justice system. In order to reduce the prevalence of adulterated samples, individuals should be supervised by a gender-matched individual while providing the sample, and a FRQ¿UPDWRU\ VDPSOH VKRXOG EH FROOHFWHG DV as possible if adulteration is suspected (Mee-Lee, 2013; Cary, 2011; NADCP, 2014). Saliva testing FDQ EH XVHG DV D FRQ¿UPDWRU\ VDOLYD collection is less easily tampered with and is relatively easy to obtain (Heltsley et al., 2012; Sample et al., 2010). Refusal to submit to drug testing and tainted samples should be regarded as positive test results. However, positive test UHVXOWV PXVW EH FRQ¿UPHG E\ XVLQJ “gold standard” testing procedures (e.g., gas chromatography/mass spectrometry–GC/MS) using the original specimen provided (Mee-Lee, 2013; Cary, 2011; Meyer, 2011; NADCP, 2014; Paparozzi & Guy, 2011).

Research examining the effectiveness of drug testing and supervision in reducing relapse, rearrest, failure to appear in court, and unsuccessful termination from probation and parole has demonstrated mixed results (Cissner et al., 2013; Gottfredson Kearley, Najaka, & Rocha, 2007; Hawken & Kleiman, 2009; Kinlock, Gordon, Schwartz, & O’Grady, 2013; Kleinpeter et al., 2010; Zweig, Lindquist, Downey, Roman, & Rossman, 2012). For example, when assessing whether pretrial drug testing reduced individual misconduct during pretrial release, drug testing was related to lower rearrest rates but not lower failure-to-appear rates at one site, and lower failure-to-appear rates but not lower rearrest rates at another site (Rhodes, Hyatt, & Scheiman, 1996). Variability in drug testing procedures (e.g., frequency, responses to positive drug tests) has been cited as a possible cause of these differences

(Carey, Finigan, & Pukstas, 2008; Kleiman, 2011; NADCP, 2014; Zweig et al., 2012).

Drug testing has different legal implications based on the stage of justice processing at which it is used (NADCP, 2014; Cary, 2011; Carey, Mackin, & Finigan, 2012; Harrell & Kleiman, 2001; Marlowe, 2011; Marlowe, 2012b). When drug testing is performed at the pretrial stage, it typically cannot be used as evidence or considered in case outcomes, unless the arrestee enters a preplea diversion program. Under these conditions, prosecution is deferred pending successful completion of a substance use treatment or other intervention program. Drug testing is often used in conjunction with treatment and sanctions after a guilty plea has been submitted and prior to sentencing. Individuals unable to remain abstinent or to otherwise abide by program requirements and guidelines in diversionary or postsentence treatment settings are often sentenced and processed through traditional criminal justice channels (NADCP, 2014; Carey et al., 2012).

methadone, naltrexone, buprenorphine) may be misused by offenders and may actually undermine substance use treatment if drug testing and careful monitoring are not provided. In other cases, drug testing may be ordered by several different treatment and service practitioners, and this information needs to be shared with staff who are providing criminal justice supervision and treatment services. Thus, it is important for staff in criminal justice settings to involve community health care practitioners in treatment planning and in ongoing discussions about medication use, including sharing of information regarding drug testing and prescription medication. This approach will assist in preventing relapse, crafting appropriate sanctions, and reinforcing the importance of drug testing as an integral part of the overall treatment plan.

Frequency of Drug Testing

Two types of testing schedules are typically used once it is determined that drug testing is appropriate for a particular individual (Robinson & Jones, 2000). "Spot testing" is usually performed if it is suspected that an individual is currently intoxicated and if a certain event occurs, such as a suspected resumption of criminal activity. Spot testing can also be useful for detecting drug or alcohol use during high-risk periods, such as weekends or holidays (NADCP, 2014). These are unscheduled and use drug-testing methods that can be administered easily and inexpensively on site. Research indicates that during the initial phases of treatment, conducting drug tests at least twice weekly are most effective because drug detection windows are 2–4 days for most types of drugs (Carey et al., 2008; Carey et al., 2012). Blood and saliva testing are the most accurate methods RI WHVWLQJ DV WKHVH DUH (Paparozzi & Guy, 2011). The utilization of breathalyzers is also useful during early stages of treatment, as well as examination for physical and behavioral signs of drug effects, such as cognitive symptoms or hand-eye coordination.

Random drug testing allows programs to discourage use while minimizing the cost of frequent testing. Individuals do not know when they will be called in for testing and as a result are less likely to use substances or to tamper with the drug testing process. Offenders in the community are often required to phone in to a central location each morning to learn if they have to submit to a drug test that day. If they are given such a notice, they are required to report for drug testing within 10–12 hours. Although it is common practice to schedule testing in weekly blocks, individuals should be tested multiple times a week, so that offenders can't anticipate what day of the week they will be tested. Testing in weekly blocks increases the chances that offenders will engage in short-term drug use, in which the drugs may be out of their system by the next drug test (Marlowe & Wong, 2008). Random drug testing is the most effective in deterring substance use because the likelihood of detection is very high (Mee-Lee, 2013; American Society of Addiction Medicine, 2010; Auerbach, 2007; Cary, 2011, McIntire et al., 2007).

Regardless of the drug testing schedule, any on-
VLWH WHVWLQJ VKRXOG EH VHQW W
of a positive result to ensure the results are legally admissible. This is particularly important for alternative drug testing methods, such as hair,
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is rarely performed, however, due to the expense of such testing. However, it is important to be
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necessary to produce this as evidence in court.

Types of Drug Testing

Several different types of drug tests are available that vary according to the level of accuracy and intrusiveness but are generally quite reliable. Six types of drug testing are commonly used in justice settings, including those that examine urine, blood, hair, saliva, sweat, and breath. Improvements in urine testing across classes of drugs include the use of portable urine technology (PUTT), which provides several advantages over larger but outdated approaches (e.g., Enzyme Multiple Immunoassay Technique –EMIT). PUTT can be provided at a relatively
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ORZ FRVW SURYLGHV IDVW DQG HI¿

offers ease of testing and interpretation. Examples of PUTT are test strips, test cups, and hand-held cassettes, which allow for frequent and random drug testing (Paparozzi & Guy, 2011). Another detection device that has gained recent attention for improving compliance among alcohol users is the Secure Continuous Remote Alcohol Monitor (SCRAM). The SCRAM device is worn on the ankle, and is able to detect alcohol vapor in sweat and to wirelessly transmit this data.

Hair testing provides an option for long-term detection of drug use, and has advantages in that it is difficult to adulterate hair samples; however, as noted in Table 1, caution should be used when conducting hair testing because of the risk for external environmental contaminants and for racial bias (Cooper, Kronstrand, & Kintz, 2012; Vignali, Stramesi, Vecchio, & Groppi, 2012).

In order to decrease the probability of external contamination, it is recommended that hair samples be taken from the scalp, as this hair has the least variability in growth, and increases the probability of detecting the ingested drug(s). Hair samples should be approximately 0.5–1 inch in length. Moreover, it is recommended that hair samples be washed prior to testing because this removes not only environmental contaminants, but also contaminants from sunscreen and hair products. Although there are no standard procedures for washing hair samples, solvents like acetone should be used because this removes external contaminants but does not remove traces of the ingested drug(s). Other solvents with methanol should not be used because these can remove traces of the ingested drug(s).

Table 1. Comparison of Alternate Drug Testing Methodologies

Sample	Invasiveness of Sample Collection	Detection Time	Cutoff Levels	Advantages	Disadvantages	Cost
Urine	Intrusion of privacy	Hours to days	Yes	High drug concentrations; established methodologies; quality control and forensic certification	Cannot indicate blood levels; easy to adulterate	Low to moderate

Hair samples should be collected within 4–6 weeks after drug ingestion to increase chances of detection. A positive hair sample should be FRQ¿UPHG ZLWK D VHSDUDWH VHFRQG KDLU VDPSOH WHVW Hair samples should be dried upon collection, as wet samples can alter analysis results (Cooper et al., 2012). Finally, it is important to consider racial bias, as it is unclear whether hair testing is equally effective in identifying cocaine use among ethnic or racial minorities. For example, studies indicate that there may be low agreement in frequency of consumption and concentration levels found in hair samples, particularly among African Americans, for whom concentrations may be higher than indicated by self-reported substance use (Vignali et al., 2012).

Other forms of urine testing are available that increase the window of detection for up to VHYHUDO GD\V IRU VSHFL¿F GHWHFWLRQ RI LQGLYLGXDO GUXJV ethyl glucuronide (EtG) and ethyl sulfate (EtS) (Cary, 2011). Procedures are also available to detect adulteration of drug test samples, including measurement of the temperature of samples (temperatures should range between 90 and 100° F), where lower temperatures may indicate tampering. Creatinine levels can also be measured, for which lower concentrations (below 20 mL) may indicate adulteration of test samples (Mee-Lee, 2013; Katz, Katz, Mandel, & Lessenger, 2007). Detailed information about each type of drug testing is included in Table 1, which also provides a comparison of key features, as well as advantages and disadvantages of the different types of drug testing. Standard procedures used by most drug-testing companies include the SAMHSA 5 (previously known as the NIDA 5), and the NIDA 7, NIDA 8, and NIDA 10, which provide testing for commonly used illegal drugs whose detection has been standardized by the National Institute on Drug Abuse (NIDA) due to the frequency of their use (Clark & Henry, 2003). The NIDA 7, 8, and 10 test for additional drugs not covered by the SAMHSA 5 panel. For example, the NIDA 8 test panel examines the following drugs:

- cannabinoids (marijuana, hash)
- cocaine (cocaine, crack)
- amphetamines (amphetamines, methamphetamines, speed)
- opiates (heroin, opium, codeine, morphine)
- phencyclidine (PCP)
- MDMA (ecstasy)
- barbiturates
- benzodiazepines

The NIDA 10-panel screen tests for hydrocodone and oxycodone in addition to the drugs in the NIDA 8 panel, while the NIDA 7 screens for MDMA in addition to the standard SAMHSA 5 drugs and distinguishes between amphetamines and methamphetamines.

Standardization of drug testing procedures DHWDEROLVP was responsible for R Y H U V H H L Q J W K H 1 D W L R Q D O / D E R U 3 U R J U D P 1 / & 3 Z K L F K F H U W L ¿ H V D recognized drug-testing laboratories. The NLCP is now operated by SAMHSA. The NIDA 8-10 panels are not typically conducted on site, and are V H Q W W R 6 $ 0 + 6 $ F H U W L ¿ H G O D E V I

In general, it is important to note the rapid development of alternative drugs that are not L G H Q W L ¿ H G W K U R X J K W K H V H V W D Q procedures, such as “Spice” and “K2.” Offenders may elect to use these during periods of drug testing (e.g., while involved in treatment) to avoid detection of cannabinoids. Thus, random testing of a wide variety of standard and alternative drugs is advised (Mee-Lee, 2013; Cary, 2011; Perrone, Helgesen, & Fischer, 2013).

Chain of Custody Process

To ensure that a drug test sample is admissible in court, documented procedures must be in place for collection, testing, and storage. Clear procedures should be established that delineate the chain of custody from the time of sample collection to the W L P H R I R I ¿ F L D O U H S R U W L Q J R I G U the justice system. All professionals involved in this process are ultimately held accountable

probation or parole, and incarceration in jail or prison.

Symptom Interaction between Co-occurring Disorders

Screening and assessment of CODs are often UHQGHUHG PRUH GLI¿FXOW E\ V\PSWRP LQWHUDFWLRQV including symptom mimicking, masking, precipitation, and exacerbation (Brady & Sinha, 2007; Horsfall et al., 2009; Schladweiler, Alexandre, & Steinwachs, 2009; Tsuang, Fong, & Lesser, 2006). Understanding these interactions is important in identifying issues that may contribute to substance use relapse, recurrence of mental health symptoms, or both (Donovan, 2005; Gil-Rivas, Prause, & Grella, 2009; Mazza et al., 2009; Schladweiler et al., 2009). Ongoing observation of symptom interaction is often needed to provide differential diagnosis of various mental and substance use disorders.

Several important types of symptom interaction should be noted:

- Use of alcohol and drugs can create mental health symptoms
- Alcohol and drug use may precipitate or elicit symptoms of some mental disorders
- Mental disorders can precipitate substance use disorders. Most individuals who have CODs indicate that mental health symptoms preceded their substance use
- Mental health symptoms may be worsened by alcohol and other drugs
- Mental health symptoms or disorders are sometimes mimicked by the effects of substance use (e.g., cocaine intoxication can cause auditory or visual hallucinations)
- Alcohol and other drug use may mask or hide mental health symptoms or disorders (e.g., alcohol intoxication may mask underlying symptoms of depression)

The considerable symptom interaction between &2'V RIWHQ OHDGV WR GLI¿FXOW\ LQ LQWHUSUHWLQJ whether symptoms are related to a mental disorder or to a substance use disorder (Steadman et al., 2013). Justice-involved individuals who KDYH &2'V PD\ KDYH GLI¿FXOW\ SUR accurate history of symptom interaction due to cognitive impairment, active mental health symptoms, confusion regarding the effects of their substance use, and to the chronic nature of their alcohol and drug use (Bradburn, 2000; Langenbucher & Merrill, 2001; Sacks, 2008). Justice-involved individuals may also anticipate negative consequences related to self-disclosure of mental health or substance use symptoms, such as placement under more restrictive conditions of supervision or placement in more intensive treatment. Alternatively, symptoms may be feigned or exaggerated if an individual believes this will lead to more favorable placement or disposition. For example, individuals who are incarcerated may falsely report mental health symptoms to receive medication, housing in medical units, or contact with medical staff.

Accuracy of Self-report Information

Screening and assessment of mental and substance use disorders in the justice system is most often based on self-report information. In general, self-report information has been found to have IDLU WR JRRG UHOLDELOLW\ DQG V not always identify the full range of symptoms of CODs (Drake, Rosenberg, & Mueser, 1996; Peters et al., 2015; Hjorthoj, Hjorthoj, & Nordentoft, 2012; Schuler, Lechner, Carter, & Malcolm, 2009; Wood, 2008). Furthermore, self-report information obtained from justice-involved individuals has been found to be valid and useful for treatment planning (Landry, Brochu, & Bergeron, 2003; Schuler et al., 2009; Peters, et al., 2015; Wood, 2008). In post-adjudicatory settings, self-reported criminal history information tends to

as accurate as data compiled from interviews or standardized instruments (Comtois, Ries, & Armstrong, 1994; DeMarce et al., 2007; Stasiewicz et al., 2008). For example, in community settings, the combination of ongoing observation, collateral reports, and interviews has produced the most accurate information regarding current alcohol use among individuals with schizophrenia (Drake et al., 1990). Substance-using associates often provide more accurate information than non-using family members regarding patterns of substance use (Hagman, Cohn, Noel, & Clifford, 2010; Kosten & Kleber, 1988). Unfortunately, individuals who have CODs often have constricted social networks and live in isolated settings, thus limiting the use of collateral informants (Drake, Alterman, & Rosenberg et al., 1993; Hawkins & Abrams, 2007; Min, Whitecraft, Rothbard, & Salzer, 2007; Stasiewicz et al., 2008).

Use of an Extended Assessment Period

Many individuals who are screened or assessed for CODs in justice settings may be under the LQÀXHQFH RI DOFRKRO RU RWKHU GUXJV 2 RUGHU WR accurately examine CODs and related issues, these individuals need to be provided a period of GHWR[L¿FDWLRQ (YHQ IRU WKRVH LO MDLO RU SULVRQ residual effects of substance use may cloud the symptom picture for several months after incarceration.

If there is uncertainty regarding recent substance use, an extended assessment period or "baseline" is recommended to help determine whether mental health symptoms are likely to resolve, persist, or worsen. While the DSM-IV-TR and DSM-5 (APA, 2000; APA, 2013) indicate that individuals should be abstinent for approximately 4 weeks before an accurate mental health diagnosis can be provided, the precise length of the extended baseline for screening and assessment should be determined by the severity of the symptoms and the general health status. The utility of screening and assessment in detecting mental health or substance use needs may be limited among justice-involved individuals whose symptoms are in temporary remission, especially if the instruments utilized focus primarily on current symptoms. It may be more relevant to examine and incorporate the history and level of psychosocial functioning during the past year in making determinations related to service and treatment needs.

> ...it is...important to reassess risk for criminal recidivism, as the specific factors that contribute to recidivism risk (e.g., criminal peers, employment, family supports) can change over time, leading to lower or higher risk levels

When using an extended assessment period, addressing acute symptoms and safety issues (e.g., suicidal behavior) should take precedence over the development of diagnoses. With careful medical assessment, psychotropic medication can be provided to treat acute mental health symptoms among individuals with CODs who are suspected of recent drug or alcohol use. Given the variability of symptoms over time among justice-involved individuals with CODs, diagnostic indicators should be continually reexamined by staff who are knowledgeable about patterns of symptom interaction. As discussed previously, it is also important to reassess risk for criminal recidivism, DV WKH VSHFL¿F IDFWRUV WKDW FR risk (e.g., criminal peers, employment, family supports) can change over time, leading to lower or higher risk levels. In many justice settings, criminal risk is reassessed via standardized risk assessment instruments approximately every 6 PRQWKV DV WKLV SURYLGHV D VXI¿

- Obtain a longitudinal history of mental health and substance use symptom onset
- Analyze whether mental health symptoms occur only in the context of substance use and identify specific types of mental health symptoms and related behavioral problems that have been elicited by prior substance use. For justice-involved individuals, it is particularly important to identify in advance the types of sanctionable behaviors that have occurred in the

are, and if they choose to begin with their mental health history, the interviewer needs to flexibly adapt to this new interview sequence

- Use motivational interviewing techniques to enhance accurate self-reporting. Key techniques include expressing empathy, fostering an understanding of the discrepancy between a person's stated life goals and current behaviors (e.g., substance use), avoiding arguing, addressing resistance by offering new options, encouraging behavior change, and supporting self-efficacy and self-confidence
- Depending on the context, use of a structured interview approach may be preferable. This may include (1) screening for consequences of substance use, (2) a lifetime history related to CODs, (3) a calendar method to document patterns of substance use in recent months (e.g., use of timeline follow-back procedure), and (4) assessment of current and past substance use
- Review the psychometric properties of available screening and assessment instruments. Research indicates that these instruments have different levels of specificity, sensitivity, and overall accuracy in justice settings and may also vary in their effectiveness with different ethnic and racial groups

Special Clinical Issues in Screening and Assessment for Co-occurring Disorders in the Justice System

Risk Assessment

Identifying "High Risk" and "High Need" Offenders

There is abundant evidence indicating that programs for offenders with CODs, where there are limited resources and where the goal is to reduce recidivism, should target those who aEMC /Span <</MCID 3885 >>BDC (s1H2 /Sscating that)Tj3ersk"

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- Substance misuse
- Family and social/relationship problems
- Education deficits
- Poor employment skills
- Lack of prosocial leisure activities

Programs for offenders with CODs should also avoid targeting areas that have been found to be unrelated to the risk for recidivism, such as self-esteem and emotional discomfort, and structured disciplinary programs, such as “boot camps”

(Casey, Warren, & Elek, 2011). Although a comprehensive description of risk assessment instruments is beyond the scope of this monograph, several commonly used instruments include the following:

- Level of Service Inventory–Revised (LSI-R; Andrews, & Bonta, 1995)
- Ohio Risk Assessment System (ORAS; Latessa, Smith, Lemke, Markarios, & Lowencamp, 2009)
- Correctional Offender Management Profiling for Alternative Sanctions (COMPAS; Brennan & Oliver, 2000)
- Wisconsin Risk/Needs (WRN; Henderson, 2007) scales and the Client Management Classification (CMC; Arling & Lerner, 1980)
- Risk and Needs Triage (RANT; Marlowe et al., 2011)
- Historical-Clinical-Risk Management-20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997)
- Short-Term Assessment of Risk and Treatability (START; Webster, Martin, Brink, Nicholls, & Middleton, 2004)
- Risk-Needs-Responsivity Simulation Tool (Crites & Taxman, 2013)

- Risk assessments should be periodically readministered to offenders with CODs, as risk level and criminogenic needs change over time. Changes detected in the overall risk level and in the pattern of criminogenic needs will help inform placement in treatment and supervision services and may signal the need for further psychosocial assessment. The frequency of reassessing risk assessments should be determined by the justice setting and the likelihood for change among the dynamic risk factors assessed. For example, people who are placed on community supervision will ordinarily have greater potential for change in dynamic risk factors related to employment, family and social supports, and substance use in comparison to people who are in custody settings

- As mentioned previously, major deficits related to criminogenic needs that are idc goaNichobjes ias, Elevel e gv[(As mc needs)Tj EM

should be validated within the specific jurisdiction and justice setting for which they are intended to be used. Validation should examine the ability of a particular instrument to accurately classify justice-involved populations into categories of risk (e.g., low, medium, and high) according to outcomes of interest, such as arrest or return to custody. This analysis determines the "positive predictive value" of the risk assessment instrument.

Evaluating Suicide Risk

More than 90 percent of people who commit suicide in the United States have a history of mental disorder(s), particularly depression and substance use (U.S. Department of Health &

This interview assessment tool addresses two important factors in determining suicide risk: (1) desire, and (2) capability to commit suicide. Desire is composed of two main components: lack of belonging to important social groups and perceived burdensomeness; for example, the individual feels like a burden to his or her family and friends. The second factor, capability, is the acquired ability to engage in self-harm, which is LQÀXHQFHG E\ IHDUOHVVQHVV RI GHDWK VXLFLGDO SODQV and preparations, and duration and intensity of suicidal ideation.

The Suicide Risk Decision Tree interview also examines other risk and protective factors to determine the overall severity of suicide risk. The Interpersonal Needs Questionnaire (INQ)/ Acquired Capability for Suicide Scale (ACSS) is a shorter, two-part self-report suicide screen based on the Suicide Risk Decision Tree (V0470044004F00030053004F0044005100560003>Tj EMC /Span <

2013; Moloney, van den Bergh, & Moller, 2009; Prendergast, 2009). High rates of PTSD are found among both men and women in the justice system. PTSD and other co-occurring drug use and mental disorders are highly prevalent in other special populations such as returning veterans. In addition to having high rates of substance use and mental disorders, returning veterans have rates of PTSD that range from 50 to 73 percent (Seal et al., 2009; 2011). There is also emerging evidence that trauma and PTSD among veterans may be related to combat or pre-military experiences. Veterans often enter the justice system due to behaviors related to mental or substance use disorders and are sometimes placed in diversion programs such as Veterans Treatment Courts (Russell, 2009; Christopher, 2010).

Given the prevalence of trauma among justice-involved individuals, trauma screening and assessment is essential in jails, prisons, and community settings. In the past, trauma-related issues have not been fully addressed in some justice settings due to concerns that staff are not adequately trained to provide treatment services or to fears that addressing these issues will disrupt treatment activities or lead to exacerbation of mental health symptoms. In fact, failure to address trauma issues often undermines engagement in treatment and may result in commonly experienced trauma-related symptoms, such as depression, agitation, and detachment, being mistakenly attributed to

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Perceived coercion (i.e., external pressures, including legal sanctions) is an important factor that affects offenders' motivation to enter and engage in treatment. Offenders who are court-referred are assumed to have been coerced to enter treatment due to legal contingencies related to reduced jail or prison time, dismissal of charges, or other factors. However, actual level of engagement in treatment is often determined by an offender's perception of choice in entering these treatment programs. Although justice involvement is related to perceived coercion, offenders typically have a choice to voluntarily enter treatment or be processed through normal judicial channels. Many offenders report that if offered, they would have entered treatment even without legal pressures (Prendergast, Greenwall, Farabee, & Hser, 2009; Farabee, Prendergast, & Anglin, 1998). Offenders' perception of coercion LV RIWHQ LQÀXHQFHG E\ WKH FRQVHTXHQFHV RI QRW engaging in treatment, with higher levels of perceived coercion related to more severe legal consequences. Interestingly, offenders who have stronger perceptions of coercion also report lower motivation to engage in treatment and readiness to change (Day et al., 2009; Prendergast et al., 2009). In summary, it is unclear to what extent perceived FRHUFLRQ LQÀXHQFHV WUHDWPHQW FRPSOHWLRQ DQG recidivism, as treatment outcomes are equivalent among coerced and voluntary participants (Prendergast et al., 2009). The best predictor of treatment outcomes may be the interaction between perceived coercion and motivation over the course of treatment (Knight, Hiller, Broome, & Simpson, 2000; Prendergast et al., 2009).

Motivation increases when continued substance use threatens current housing, involvement in mental health treatment, vocational rehabilitation, family and relationships, and when continued substance use will lead to incarceration (Peters & Young, 2011; Ziedones & Fisher, 1994). Drug courts and other coerced drug treatment programs allow offenders to gain insight into their addiction and co-occurring disorders and to receive a comprehensive range of services to address psychosocial problems. Although participants in drug courts and other coerced treatment programs do not typically have high internal motivation to change their behaviors during early stages of treatment, they often develop internal motivation after engaging in intensive services, observing progress among other participants, and addressing their own ambivalence to make major lifestyle changes.

People in the justice system who have CODs may not be as motivated to enter treatment as those who have substance use disorders alone (Horsfall et al., 2009; Drake et al., 2008). Those who have CODs often experience a range of problems that contribute to low motivation, which can lead WR GLI¿FXOW\ HQJDJLQJ LQ WUHDW drop-out, relapse, and other adverse outcomes (Barrowclough, Haddock, Fitzsimmons, & Johnson, 2006; Gregg et al., 2007; Horsfall et al., 2009). For example, the presence of severe mental health symptoms can inhibit treatment engagement and motivation. Justice-involved people who have CODs frequently have low tolerance to stress, low cognitive functioning, poor coping skills, and poor psychosocial functioning, which often prevent meaningful participation in treatment and recognition of the need for treatment and behavior change (DiClemente et al., 2008; Carey, Maisto, Carey, & Purnine, 2001; Gregg et al, 2007; Horsfall et al., 2009).

Offenders who have CODs may also lack the interpersonal skills necessary to establish a healthy social support system and to work effectively with others in a structured treatment setting. Without the presence of a strong social support system, these individuals may have increased GLI¿FXOW\ FRSLQJ ZLWK UHODWHG during treatment, which can result in resorting to substance use as a coping mechanism (Horsfall et al., 2009). Even people who are medically managed for their mental health symptoms may KDYH GLI¿FXOW\ ¿QGLQJ HQHUJ\ WR in treatment, due to the side effects of their medications (Gregg et al., 2007; Horsfall et al., 2009). Moreover, changing motivation among people who have CODs may be problematic

during treatment because of the cognitively taxing nature of activities such as goal setting, decision-making, and cognitive-behavioral skill development (DiClemente et al., 2008). Another issue is that people who have CODs may be motivated to change their thoughts and behaviors related to substance use but not their mental disorders (DiClemente et al., 2008; Heesch, Velasquez, & von Sternberg, 2005; Freyer et al., 2005).

Treatment of CODs in the justice system typically involves constructing several targeted goals relevant to substance use, mental disorders, and other related issues. Targeting multiple problems and goals may be confusing and

“stages of change” during the course of treatment and recovery. In the early stages of change, people who have CODs may not recognize the importance of substance use disorders or other psychosocial problems that complicate treatment and are unlikely to commit to changing their substance use behavior and to the goals of treatment. In the justice-involved population, with the chronic relapsing nature of recovery from substance use and mental disorders and the presence of antisocial beliefs, attitudes, and peers, movement through stages of change does not typically follow a linear pattern. For example, justice-involved individuals who have CODs frequently return to previous stages of change before achieving sustained abstinence and recovery.

Several stages of change related to addictive behaviors are described by the “transtheoretical

among people who have CODs, and individuals of racial or ethnic minorities are consistently less likely than their White counterparts to seek treatment for both substance use and mental disorders (Hatzenbuehler et al., 2008). Ethnic and racial minorities also tend to have lower rates of successful treatment completion and higher rates of recidivism (Belenko, 2001; Finigan, 2009; Marlowe, 2013; NADCP, 2014). Individuals who have experienced shame and social exclusion may KDYH UHGXFHG VHOI HI¿FDF\ UHODWHG WR UHFRYHU\ DQG may anticipate that treatment staff will judge them negatively, thus affecting treatment outcomes.

Experiences of poverty, discrimination, and involvement with the criminal justice system may also increase vulnerability and exposure to chronic stress among ethnic and racial minorities (Marlowe, 2013; NADCP, 2014) and shape underlying belief systems of individuals regarding treatment and recovery processes. One apparent consequence is that minorities who have CODs are more likely to report seeking self-help (e.g., AA/NA) services to deal with substance use problems and are less likely to seek mental health treatment (Hatzenbuehler et al., 2008). Minorities may also experience discrimination in assignment to different types of treatment and in the type of sanctions provided within the justice system and are less likely to receive certain types of rehabilitative services (Justice Policy Institute, 2011; Marlowe, 2013; Nicosia, MacDonald, & Pacula, 2012; NADCP, 2014). In some cases, discriminatory policies in justice settings have led to coercing minorities who have CODs into substance use treatment rather than specialized mental health services (Hatzenbuehler et al., 2008).

Symptoms of mental disorders may be expressed very differently among ethnic and racial minorities. Unless cultural norms are well XQGHUVWRRG DQG VXI¿FLHQW IROORZ XS WLPH LV
, (bes viorsng tespan orders EMC /mis<</eran TMCID 5078 >>BDC 0 -1.273 T9s and are leslea<</MC003m

NADCP, 2014). One apparent example is that Latinos born in the United States are more likely to identify themselves as having CODs in comparison to their foreign-born counterparts. The likely rationale for this is not underreporting among foreign-born Latinos but rather the lack of assimilation to American culture that may serve as protective factors against developing CODs (Vega, Canino, Cao & Alegria, 2009).

Different beliefs, expectations, and levels of D F F X O W X U D W L R Q F D Q L Q À X H Q F H and outcomes among justice-involved individuals who have CODs. Research indicates that attending to cultural beliefs through appropriate staff training improves outcomes in substance use treatment (Guerrero & Andrews, 2011; Northeast Addiction Technology Transfer Center [ATTC], 2008; NADCP, 2014). Matching ethnic and racial minorities to integrated treatment services in the justice system that are culturally sensitive can also improve treatment outcomes (Marlowe, 2013; Northeast ATTC, 2008). It should be noted, however, that few specialized CODs treatment interventions have been developed for ethnic and racial minorities, and there are few evidence-based protocols to help organize this type of specialized treatment.

Some individuals in the justice system who have CODs may not be fully candid during screening and assessment interviews because their cultural D I ¿ O L D W L R Q G R H V Q R W F R Q G R Q H V H O I G L V F O R V X U H R I problems to those outside of the immediate family. Self-disclosure may also be inhibited among individuals who have experienced discrimination from people who share the culture or ethnicity of the staff person conducting screening or assessment interviews. Some minorities may consider themselves undeserving of CODs treatment due to the combined stigma attached to endorsing a co-occurring disorder and minority status (Lawrence-Jones, 2010).

/ D Q J X D J H E D U U L H U V F D Q D O V R L Q À X H Q F H W K H R X W F R P H of screening and assessment interviews among justice-involved individuals who have CODs. Alternative strategies should be explored for individuals who do not read or comprehend English effectively. Whenever possible, screening and assessment should be conducted in the individual's language of choice and by staff from a similar cultural background. Many screening instruments are available in Spanish or other languages, and whenever possible, bilingual staff should conduct screening and assessment interviews.

Q F K D Y L Q J V W D I I W U D L Q H G L Q F X O W X U D O H Q W Having staff diverse in ethnic or cultural backgrounds is highly important in promoting effective participation in screening, assessment, and other treatment activities. Given that this can be challenging, it is also helpful to periodically assess the cultural competencies of justice programs that serve offenders who have CODs. One approach is to use a semi-structured self-assessment protocol (Osborne, 2008) to review data collection procedures, staff training, staff diversity (e.g., diverse racial and ethnic background), multilingual abilities, availability of cross-cultural screening and assessment tools, and use of culturally sensitive treatments. Results of this self-assessment can be used to improve program services by identifying staff training needs, gaps in services, and minority groups that are underrepresented among program and treatment staff.

Staff Training

Those working in justice settings, including judges, prosecutors, defense counselors, treatment staff, case managers, court personnel, correctional R I ¿ F H U V S U R J U D P G L U H F W R U V D Q supervision staff, are often inadequately trained L Q L G H Q W L ¿ F D W L R Q D V V H V V P H Q W and supervision of individuals with CODs (Steadman et al., 2013). For example, screenings are often conducted by staff who lack training or experience related to mental or substance use disorders and who may be unfamiliar with related treatment services for these disorders in the justice system. In recent years, a specialized base of knowledge and set of skills have been developed

for working with justice-involved individuals who have CODs. Training in these areas should be provided for all staff who are involved in screening and assessing CODs in the justice system.

One of the challenges inherent to training is

Instruments for Screening and Assessing Co-occurring Disorders

Screening and assessment of CODs in the justice system should incorporate use of standardized instruments that have been validated with offender populations. Use of standardized instruments will enhance the consistency of information gathered during this process and will promote a shared understanding of important domains to be reviewed in addressing CODs. Standardized instruments that yield summary scores and scores across different domains provide a common vocabulary for staff to communicate needs for treatment, supervision, and monitoring (Fletcher et al., 2009; Taxman, Cropsey et al., 2007) across different justice settings, such as courts, probation, and reentry from custody. However, many criminal justice programs do not administer standardized instruments (Cropsey et al., 2007; Friedmann et al., 2007) and instead use improvised screening and assessment techniques that have questionable validity and that may lead to poor outcomes among offenders who have CODs.

Given the absence of specialized screening instruments that address the multiple relevant components of CODs, several instruments (e.g., mental health, substance use, trauma/PTSD, motivation) are often combined to provide a comprehensive screening. These screening instruments are sometimes included in a battery to provide focused information regarding acute mental health and substance use needs and

- Correctional Mental Health Screen (CMHS-F/ CMHS-M)
- Mental Health Screening Form-III (MHSF-III)

- Recommended screening instruments for substance use disorders
  - Texas Christian University Drug Screen V (TCUDS V) (Note: To conduct a screening that includes more detail about alcohol use, the AUDIT can be combined with the TCUDS V or the SSI instrument.)
  - Simple Screening Instrument (SSI)
  - Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
  - TCU Drug Screen V (TCUDS V)
  - Alcohol Use Disorders Identification Test (AUDIT)*
  - Simple Screening Instrument (SSI)
  - Alcohol Use Disorders Identification Test (AUDIT)
- Recommended screening instruments for co-occurring disorders
  - Mini International Neuropsychiatric Interview-Screen (MINI-Screen)
  - Brief Jail Mental Health Screen (BJMHS) and TCU Drug Screen V (TCUDS V)
  - Correctional Mental Health Form (CMHS-F/CMHS-M) and TCU Drug Screen V (TCUDS V)
- Recommended screening instruments for motivation and readiness
  - Texas Christian University Motivation Form (TCU MOTForm)
  - University of Rhode Island Change Assessment Scale-M (URICA-M)
- Recommended screening instruments for trauma history and PTSD
  - The Trauma History Screen (THS), or
  - Life Stressor-Checklist (LSC-R), or
  - Life Events Checklist for DSM-5 (LEC-5), and
  - Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)
- Recommended screening instruments for suicide risk
  - Interpersonal Needs Questionnaire (INQ), combined with the Acquired Capability Suicide Scale (ACSS)
  - Beck Scale for Suicide Ideation (BSS)
  - Adult Suicidal Ideation Questionnaire (ASIQ)

6 S H F L ¿ F L Q V W U X P H Q W V D U H U H F R P screening of mental disorders, substance use disorders, co-occurring mental and substance use disorders, motivation and readiness for treatment, trauma/PTSD, and suicide risk. These screening These scrTjDductn c 5preh to12 0use

- Diagnostic instruments should have good interrater reliability and validity
- Diagnosis should be based on observation of mental health and substance use symptoms over time, and diagnostic interviews should be supplemented by review of collateral sources of information and by drug testing, whenever feasible
- Diagnoses of individuals with CODs should be reviewed periodically, given that key symptoms often change over time (e.g., following periods of prolonged abstinence)

Recommended Instruments for Assessment and Diagnosis of Co-occurring Disorders

Few instruments have been validated for use in assessing individuals with CODs. Moreover, few studies have occurring Disn <<toC /Span </MfferEMC typ.5(>>BDC 0 -1.273 TD [(studi5s have)ce use .2 TD

These instruments are based on a critical review of the research literature examining both assessment and diagnostic instruments for use with CODs. A comprehensive review of assessment and diagnostic instruments ("Assessment and

(Richards & Pai, 2003). A range of substance use screening instruments are reviewed in this section that can assist in detecting co-occurring disorders (CODs), with information provided about positive features and concerns related to each instrument.

Changes to the DSM-5 Diagnostic & O D V V L ¿ F D W L R Q 6 \ V W H P

Several substance use disorders are described in the section of the DSM-5 (APA, 2013) entitled "Substance-Related and Addictive Disorders." Substance use and substance dependence are no longer considered separate disorders as they were in DSM-IV, and have been combined into a single disorder ("substance use disorder") that measures severity of symptoms on a continuous scale from mild to severe. The new DSM-5

- The ADS is unidimensional, as intended, and has good internal consistency (alpha = .90; Kahler, Strong, Stuart et al., 2003)
- ADS scores are significantly correlated with objective measures of alcohol use severity among incarcerated men (Hodgins & Lightfoot, 1989)
- The ADS is most effective in detecting moderate to severe levels of alcohol use (Chantarujikapong et al., 1997)
- The ADS in combination with the Addiction Severity Index (ASI)–Drug Use section was one of three screening instruments found to be the most effective in identifying substance use among prisoners (Peters & Greenbaum, 1996)
- The ADS was the most accurate of several screening instruments in detecting alcohol disorders among justice-involved individuals (Peters et al., 2000)
- In determining substance use disorders among offenders, the ADS exhibited adequate sensitivity (74 percent, 66 percent), specificity (92 percent, 97 percent), positive predictive value (89 percent, 98 percent), and negative predictive value (80 percent, 69 percent) respectively (Peters et al., 2000)
- The ADS performed as well as the Michigan Alcoholism Screening Test (MAST) in detecting alcohol use disorders (Ross et al., 1990)
- In an addictions setting, at a cut-off score of 8 or 9, the ADS has good sensitivity (91 percent), specificity (82 percent), positive predictive value (93 percent), and negative predictive value (76 percent; Ross et al., 1990)
- A 12-item version of the ADS can reliably discriminate between levels of alcohol severity in treatment-seeking populations (Kahler, Strong, Hayaki et al., 2003)
- The ADS provides both cut-off scores that indicate the presence of an alcohol use disorder and treatment
- The ADS has been found to have test-retest reliability of .92–.98 over a 1-week period (Addiction Research Foundation, 1993; Peters et al., 2000)
- Computerized versions of the ADS are available through the Computerized Lifestyle Assessment. Miller and others (2002) report high test-retest reliability of this version (r score = .84–.93) over a 1-week period

Concerns

- The ADS does not examine quantity or frequency of recent and past alcohol use
- The ADS is limited to screening for alcohol use problems
- The superficial nature of ADS items may result in underreporting of symptoms
- Additional validation in subpopulations may be necessary (e.g., pregnant women)
- The ADS does not always exhibit substantial agreement across types of reporting (e.g., self-report, report by service/agency staff), with one study indicating only a 15 percent rate of agreement in a treatment-seeking population
- The ADS is a commercial product, although the cost is quite modest

Availability and Cost

The ADS is a copyrighted document that can be obtained from its author. The price of $15 includes a userThe price of $15

Computerized versions of the ADS can be obtained by contacting the Multi-Health Systems regarding and requesting the Computerized Lifestyle Assessment: 1-800-456-3003 (U.S.); 1-800-268-6011 (Canada).

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

The ASSIST (World Health Organization [WHO] ASSIST Working Group, 2002) was developed for the WHO by an international group of substance use researchers to address the need for a comprehensive screening instrument in primary health care settings. The original 12-item instrument was developed through identifying psychometrically sound items from other substance use screens, based on a comprehensive review of the literature (Babor, 2002). The ASSIST measures frequency of substance use; current symptoms (i.e., in the past 3 months); and problems related to alcohol, tobacco, and other drugs. The ASSIST includes a brief introduction describing the purpose of the measure, and items are grouped by type of substance (e.g., alcohol, cannabis, opioids, stimulants, tobacco). Item 1 provides a brief screen for lifetime use of each type of substance.

The remaining items on the ASSIST examine current frequency of substance use by type of substance, and frequency of related symptoms during the past 3 months. For example, item 2 inquires about current frequency of use ("how often have you used the substance in the past 3 months?"). Subscales of the ASSIST include 6SHFL¿F 6XEVWDQFH ,QYROYHPHQW, 6ORU, the Federal items 2–7 for each type of substance) and Total Substance Involvement (TSI; sum of items 1–8 across each type of substance). Item 8 inquires about intravenous (IV) drug use in the past 3 months. The ASSIST provides feedback to respondents indicating the level of their SSI score by severity of risk for substance use problems according to designated cut-off scores (low risk ± PRGHUDWH ± KLJK • DOG SK\VLFDO ORZ ULVN " PRGHUDWH ULVN and mental health risks associated with these scores. The risk levels are also intended to distinguish between low, medium, and high risk. An integrated set of brief interventions provides feedback regarding health risks for each substance class.

0RGL¿FDWLRQV WR WKH LQVWUXPH reduced the number of items to eight, and improved the psychometric properties. The most recent version (ASSIST 3.0) provides standardized cut-off scores across different types of substances. 7KH 1,'$ KDV PRGL¿HG WKLV PHDVX two parts: (1) the "NIDA Quick Screen," and (2) WKH ³1,'$ 0RGL¿HG $66,67 ´ ZKLFK S more comprehensive assessment for individuals who surpass the cut-off score on the Quick Screen. The Quick Screen inquires only about past year use of alcohol, tobacco, and drugs. The ASSIST has been widely adapted for use in different cultures and has been translated into several languages. This instrument can be administered as an interview or by self-report.

Positive Features

- The ASSIST is available at no cost, is quite brief to administer, and includes scoring and interpretation of scores (e.g., level of treatment needs) according to risk level
- The ASSIST evaluates lifetime substance use, current substance use, severity of substance use, and risk related to IV drug use
- The ASSIST 3.0 includes weighting and recoding analyses that provide a consistent cut-off score for substance use
- The ASSIST uses an approach that is consistent with the federally funded Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative in that accompanying materials are provided to implement brief interventions and referral to treatment, based on ASSIST findings related to risk level and type of substance(s) used
- The ASSIST includes cut-off scores for differentiating between severity of use

substance use among men and Hispanics, relative to other groups (Smith et al., 2010)

Availability and Cost

The most recent version of the ASSIST (3.0) is available at no charge via electronic download and includes the screening tool, user's manual, patient feedback card, as well as self-help strategies for managing substance use. The instrument can be obtained at the following site: http://www.who.int/substance_abuse/activities/assist/en/index.html

Hispanic, Asian, and African American men and women (Adewuya, 2005; Cherpitel, 1998; Meneses-Gaya et al., 2010; DeSilva, Jayawardana, & Pathmeswaran, 2008; Gomez et al., 2006; Giang et al., 2005; Wu et al., 2008), and is effective in identifying risky drinking and alcohol use disorders among a variety of populations (Cassidy et al., 2008; Caviness et al., 2009; DeSilva et al., 2008; Doyle et al., 2007; Meneses-Gaya et al., 2010; Tuunanen, et al, 2007)

- The AUDIT has good sensitivity and adequate specificity in identifying risky drinking and alcohol use disorders among college students (Kokotailo et al., 2004)
- Non-English versions of the AUDIT provide adequate internal consistency (Reinhert & Allen, 2007). Test-retest reliability of these versions are also acceptable (kappas range .69–.86; Dybek et al., 2006; Selin, 2003)
- The AUDIT-C demonstrates good sensitivity and specificity (81–95 percent and 73–91 percent, respectively) for identifying harmful drinking patterns and current alcohol use disorders at varying cut-off scores (ranging 2–7) across groups that differ by gender, population, and culture (Bradley et al.,2007; Bradley et al., 2003; Caviness et al., 2009; Dawson, Grant, Stinson & Zhou, 2005; Frank et al., 2008; Gual, Segura, Contel, Heather, & Colom, 2002; Seale et al., 2006)
- The AUDIT-C demonstrates good internal consistency in both clinical and college samples (.74 and .81 respectively; Shields et al., 2004) and high test-retest reliability (r score = .98; Bergman and Kallman, 2002)
- The FAST has been validated in several settings and demonstrates good psychometric properties (Hodgson et al., 2002). The FAST is correlated with other well-validated screening measures of alcohol use disorders, including the AUDIT, PAT (Paddington Alcohol Test), and the CAGE. The FAST has good sensitivity (91 percent) and specificity (93 percent) in detecting alcohol use disorders and demonstrates better psychometric properties than the CAGE and PAT (Hodgson et al., 2002)
- Among adolescents, the AUDIT has greater sensitivity than the CAGE in detecting
- alcohol use disorders of varying severity (Knight, Sherritt, Harris, Gates, & Chang, 2003) and has been shown to have good concurrent and criterion validity (Kelly, Donovan, Kinnane, & Taylor, 2002; Knight et al., 2003) and reliability (Kelly et al., 2002). No gender differences were found in using the AUDIT among adolescent inpatients (Kelly et al., 2002). At a cut-off score of 2 for identifying problematic alcohol use among adolescents, the AUDIT's sensitivity was 88 percent and the specificity was 81 percent (Knight et al., 2003)

Concerns

- The AUDIT has lower reliability in alcohol drinkers with low levels of consumption
- The AUDIT may be more effective in identifying needs for assessment and treatment for justice-involved individuals when conducted several weeks after entry to prison (Maggia et al., 2004), as shown by the weak agreement in classification between initial screening and later screening (kappa = .27)
- The AUDIT-CSI is somewhat invasive and must be conducted by a trained clinician
- The AUDIT-C may be better at identifying alcohol use disorders in women than men (Dawson, Grant, Stinson, & Zhou, 2005)
- The AUDIT and the AUDIT-C are less sensitive and more specific with females (Reinert & Allen, 2002; Bradley et al., 2003) and are generally more effective screens for alcohol use disorders among women (Dawson, Grant, Stinson, & Zhou, 2005)
- Some have recommended that cut-off scores should be lowered when the AUDIT and AUDIT-C are used with women, and these scores have varied across female samples (Bradley et al., 2007; Bradley et al., 2003; Chung, Colby, Barnett, & Monti, 2002; Gache et al., 2005; Gual et al., 2002; Neumann et al., 2004), although there is little research to validate the use of specific cut-off scores for this purpose
- AUDIT-C item 3 may contribute to the sensitivity and specificity differences (Bradley et al., 2003) among female respondents
-

is agreement between computerized and in-person interviews (.77; Bernadt, Daniels, Blizard & Murray, 1989)

- Internal consistency of the CAGE across clinical and nonclinical samples averages .74 (Shields & Caruso, 2004)
- The CAGE is highly correlated with other validated measures of alcohol use disorders, such as the SMAST (Hays & Merz, 1995), and the CAGE-AID is highly correlated with the AUDIT (Leonardson et al., 2005), supporting the convergent validity of these instruments
- The test-retest reliability of the CAGE was found to be .80 among psychiatric outpatients, and .95 in a community sample (Teitelbaum & Carey, 2000)
- The CAGE more effectively classifies college students than the SASSI-3 (Clements, 2002). The CAGE has also been found to effectively distinguish between adolescents who have alcohol use disorders and those who do not have these disorders (Hays & Ellickson, 2001)
- The CAGE-AID has greater sensitivity and lower specificity for substance use disorders in comparison to the CAGE. The CAGE-AID has greater sensitivity than the CAGE across gender, income, education, and different types of substance use disorders (Brown & Rounds, 1995)
- The CAGE-AID shows high internal consistency (r score= .92; Leonardson et al., 2005)

Concerns

- The CAGE does not examine quantity or frequency of recent and past substance use and examines a narrow range of diagnostic symptoms related to alcohol use disorders
- The CAGE has not been widely validated for use in justice settings
- The CAGE may have lower test-retest reliability among psychiatric patients than in other populations (r score = .67; Dyson et al., 1998)
- The reliability of the CAGE ranges greatly (.52–.90) across different samples (Shields & Coruso, 2004)
- Interrater reliability of the CAGE for diagnosis of substance use disorders is quite low (kappa = .15; Indran, 1995)
- The CAGE does not effectively discriminate between heavy and non-heavy drinking in the general population (Bisson, Nadeau, & Demers, 1999). Due to the focus on lifetime problems, the CAGE does not differentiate between people with chronic alcohol problems and those who have not experienced problems in many years (Bradley et al., 2001)
- Within general population samples, no CAGE cut-off score provides concurrently high specificity, sensitivity, and positive predictive value (Bisson et al., 1999)
- The CAGE sometimes provides low sensitivity in classifying alcohol use disorders (Maisto, & Saitz, 2003), and there is wide variability in the instrument's sensitivity (43–94 percent)
- Higher CAGE cut-off scores provide better specificity and sensitivity in primary care settings than in other settings (Aertgeerts et al., 2004)
- The CAGE is more accurate in classifying males than females (McHugo et al., 1993). The instrument underestimates alcohol problems among females (Bisson et al., 1999; Cherpitel, 2002; Matano, Wanat, Westrup, Koopman & Whitsell, 2002; Moore, Beck et al., 2002). The CAGE also has lower sensitivity among White females than African American females (Bradley, Boyd-Wickizer, Powell, & Burman, 1998)
- The CAGE has higher sensitivity among African Americans than Whites (Cherpitel 2002)
- Translation and cultural differences may affect responses on the CAGE (Steinbauer et al., 1998)
- The CAGE has low sensitivity among elderly psychiatric samples (O'Connell et al., 2004)

- The CAGE is not recommended for use with adolescents (Hays & Ellickson, 2001; Knight et al., 2003) and has performed poorly in college samples (Aertgeerts et al., 2000; Bisson et al., 1999)
- Several alternate versions (LAST, 5-shot, Augmented CAGE) have better psychometric properties than the CAGE in detecting alcohol use problems and disorders (Bradley, Bush et al., 1998; Rumpf et al., 1997; Seppet al., 1998)

Availability and Cost

The CAGE is available free of charge, and the instrument and scoring information can be found at either of the following sites:

- http://bit.ly/CAGE_inst
- http://www.projectcork.org/clinical_tools/html/CAGE.html

The CAGE can also be obtained in the document: Ewing, J. A. (1984). Detecting alcoholism: the CAGE questionnaireJournal of the American Medical Association, 252(14), 1905–1907.

The Dartmouth Assessment of Lifestyle Instrument (DALI)

The DALI is an 18-item, interview-administered scale that examines lifetime alcohol, cannabis, and cocaine use disorders among people with severe mental illness. The DALI is a composite of several different instruments and includes 3 items from the Life-Style Risk Assessment Interview and the remaining 15 items from the Reasons for Drug

Drug Abuse Screening Test (DAST)

The DAST (Skinner, 1982) is a brief screening instrument that examines symptoms of substance use disorders. Several versions of the DAST are available, including the original DAST-28, DAST-20, DAST-10, and DAST for Adolescents (DAST-A). The DAST reviews drug and alcohol problems occurring in the past 12 months. Items from the DAST were developed to align with those developed for the Michigan Alcoholism Screening

- The DAST-A has been found to be a reliable and valid screening device for use with adolescents in psychiatric settings and includes wording tailored for adolescents (Martino et al., 2000). The DAST-A is more likely to underestimate than overestimate substance use problems

Concerns

- The DAST does not examine the quantity or frequency of recent or past substance use and is limited to screening for drug problems
- The validity of the DAST has not been widely examined among individuals with CODs
- There is some evidence that the DAST may consist of five factors, departing from other findings of the unidimensional nature of the instrument (El-Bassel et al., 1997; Yudko et al., 2007). Several studies also indicate that the DAST-20 and DAST-10 have a multidimensional factor structure (Cocco & Carey, 1998; Saltstone et al., 1994; Skinner & Goldberg, 1986; Yudko et al., 2007)
- Research indicates that the DAST-10 may yield a high number of "false negatives" (McCann et al., 2000)
- Studies of the DAST-A have not extensively examined criterion validity (Martino et al., 2000)
- The DAST-28 has several potentially problematic items (items 7 and 20) that are not highly correlated with the overall DAST score (El-Bassel et al., 1997; Skinner, 1982; Staley & El-Guebaly, 1990; Yudko et al., 2007). Similarly, items 4 and 5 of the DAST-20, DAST-10, and item 20 of DAST-A are not highly correlated with the total score (Cocco & Carey, 1998; Martino et al., 2000; Yudko et al., 2007)
- The DAST may result in underreporting or denial of symptoms due to the face validity of test items (El-Bassel et al., 1997; Skinner, 1982; Yudkho et al., 2007). The DAST-A is susceptible to faking good in adolescent populations (Yudko et al., 2007)
- The DAST is a commercial product, although the cost is quite modest

Availability and Cost

The Drug Abuse Screening Test (DAST) instrument can be obtained by contacting The Addiction Research Foundation, Marketing Department, 33 Russell Street, Toronto, Ontario, Canada M5S-2S1 at (416) 595-6000. Additional information regarding the DAST can be obtained at the following sitehttp://bit.ly/DAST_inst

The DAST can also be downloaded, with information regarding scoring and interpretation of test scores, at the following site:http://www.projectcork.org/clinical_tools/html/DAST.html

Michigan Alcoholism Screening Test (MAST)

The MAST (Selzer, 1971) is a self-administered screening instrument that consists of 25 items related to drinking behavior, symptoms, and consequences of use. The MAST is a public domain instrument that was developed through funding by the NIAAA. The screen uses a yes/no

1996). The recommended cut-off score for
LGHQWLI\LQJ SUREOHP GULQNLQJ ZLWK WKH 0$67 LV • 6HO]HU ZLWK WKH 60$67 LV • 6HO]HU HW DO ZLWK WKH E0$67 LV • 3RNRUQ\ HW DO ZLWK WKH 0$67 * LV • 0RUWRQ HW DO DQG ZLWK WKH 60$67 * LV • %ORZ HW DO
1998).

Positive Features

- The MAST is available in the public

the SBIRT approach can be readily adapted for use in justice settings in which there is a high volume of offenders screened who are in potential need of

more intensive treatment (4–16 percent), resulting in over 63 percent receiving some type of treatment (Madras et al., 2009)

- SBIRT interventions that involve referral

brief SBIRT interventions did not show a significant reduction in alcohol use relative to a comparison group

- Substance use screening generally employs self-report screening instruments, which may not be as accurate as clinical interviews or the use of self-report instruments in combination with drug testing (Vitale, van de Mheen, van de Wiel, & Garretsen, 2006)
- Additional research is needed to examine the stability of SBIRT-related reductions in substance use over time during follow-up periods of greater than 6 months (Madras et al., 2009)
- SBIRT studies with adolescents have yielded inconsistent results in reducing substance use and are compromised by several methodological problems (Bernstein et al., 2010; Spirito et al., 2011)

SBIRT Resources

Several resources for developing and implementing an SBIRT approach for screening, brief interventions, and referral to treatment are provided at the following sites:

http://www.samhsa.gov/sbirt

http://www.drugabuse.gov/publications/resource-guide

http://www.samhsa.gov/sbirt

http://www.cdc.gov/ncbddd/fasd/documents/alcoholsbiimplementationguide.pdf

Billing codes for SBIRT service are available at the following sites:

http://www.wiphl.org/uploads/media/SBIRT_Manual.pdf

https://www.whitehouse.gov/sites/default/files/page/files/sbirt_fact_sheet_ondcp-samhsa_7-25-111.pdf

Simple Screening Instrument for Substance Abuse (SSI)

The Simple Screening Instrument for Substance Abuse (SSI; CSAT, 1994) is a 16-item screening instrument that examines symptoms of severe alcohol and drug use disorders that have been experienced during the past 6 months. The instrument was developed by SAMHSA's Center for Substance Abuse Treatment (CSAT) through selection of items from eight existing screening instruments and from the DSM-III-R. The SBsting-1.273 t0ev SBIR

- The SSI functions as intended as a unidimensional measure (Boothroyd, Peters, Armstrong, Rynearson-Moody & Caudy, 2013)
- The SSI has good convergent validity with other substance use measures among justice-involved individuals (O'Keefe, Klebe & Timken, 1999)
- The SSI has good convergent validity, and at a cut-off score of 4, has moderate to large effect sizes in identifying people who need substance use treatment, those who have used substances in the past month, those reporting functional deficits, and those who have lower levels of "quality of life" (Boothroyd et al., 2013)
- The SSI exhibits good sensitivity (82 percent), specificity (90 percent), positive predictive value (99 percent), and negative predictive value (37 percent) in a Medicaid population. These psychometric properties are not influenced by ethnicity or gender (Boothroyd et al., 2013)
- The SSI has good sensitivity at a cut-off score of 1 in detecting substance use disorders among college students (Kills Small, Simons & Stricherz, 2007) and was correlated with several other validated measures of substance use disorders (i.e., the AUDIT, Rutgers Alcohol Problem Index-RAPI, and Daily Drinking Questionnaire-DDQ)
-

the probability of a substance use disorder. The decision rules in making this determination are somewhat different for males and females.

The instrument may be administered via paper and pencil or by computer (Swartz, 1998). The SASSI-A has been developed for use with adolescents. The recommended cut-off score as indicated by the SASSI-3 user's guide for identifying severe substance use disorders among DGXOWV LV • ZLWK PDOHV DQG • ZLWK IHPDOHV (Miller, Roberts, Brooks & Lazowski, 1997).

Positive Features

- Researchers at the SASSI Institute report that the SASSI, SASSI-2 and SASSI-3 (Miller & Lazowski, 1999) have high sensitivity, specificity, and positive predictive value (Lazowski et al., 1998) across a range of settings
- The SASSI adult manual indicates adequate classification rates of substance use disorders (62 percent; Bauman Merta & Steiner, 1999)
- Several studies examining the SASSI-3 (Arenth, Bogner, Corrigan, & Schmidt, 2001; Ashman, Schwartz, Cantor, Hibbard, & Gordon., 2004) indicate adequate sensitivity (72–85 percent), specificity (63–82 percent), positive predictive value (68–76 percent), and negative predictive value (74–84 percent)
- The SASSI demonstrates adequate agreement with the CAGE and the MAST (Laux, Salyers, & Kotova, 2005; Myerholtz & Rosenberg, 1998)
- The SASSI "direct" scales perform relatively well in classifying substance use disorders (84–89 percent) and perform better than the total SASSI score in this regard (Ashman et al., 2004; Clements, 2002; Gray, 2001; Swartz, 1998)
- The SASSI-A scales have demonstrated good construct validity (Stein et al., 2005), and adequate internal consistency (alphas range .66–.74) is reported with the direct scales (Makini et al., 1996; Nishimura et al., 2001)
- In one study, the SASSI-A accurately classified 76 percent of people who did not admit to alcohol and drug use problems (Rogers, Cashel, Johansen, Sewell, & Gonzalez, 1997)
- Studies indicated good 1- and 2-week test-retest reliability and internal consistency for the SASSI's "face valid" subscales (Clements, 2002; Gray, 2001; Laux, Perera-Diltz, Smirnoff, & Salyers, 2005; Laux, Salyers et al., 2005; Lazowski et al., 1998)

Concerns

- The SASSI is a commercial product and is quite expensive in comparison to other substance use screening instruments
- The SASSI was found to be the least effective of eight screening instruments in identifying severe substance use disorders among incarcerated offenders (Peters et al., 2000). The SASSI had among the lowest overall accuracy (60 percent) of the eight substance use screens examined in the study and had the lowest specificity (52 percent) of the five screening instruments that specifically examined drug use disorders, including the Simple Screening Instrument (SSI) and Texas Christian University Drug Screen (TCUDS) that are described in this monograph
- The SASSI does not address a unitary construct and instead examines several underlying factors, in contrast to the intent of the instrument (Gray, 2001; Rogers et al., 1997; Stein et al., 2005; Sweet & Saules, 2003). The SASSI appears to have

scoring keys are inconsistent with the factor structure that was obtained using a large offender population (Gray, 2001)

v

there is no empirical evidence to support these interpretations (Feldstein & Miller, 2007)

- The SASSI-3 and SASSI-A are no more effective than several briefer screening instruments in detecting substance use disorders (e.g., CAGE, DAST, MAST; Clements, 2002; Rogers et al., 1997)
- The SASSI-A Correctional (COR) scale does not appear to be related to measures of criminal activity and thus may be of limited value in predicting recidivism (Stein et al., 2005)
- No studies report internal consistency for the full SASSI-A (Feldstein & Miller, 2007)

Availability and Cost

The SASSI-3 costs approximately $140 for a set of materials that includes the administration manual, a user's guide, a scoring key, and 25 T X H V W L R Q Q D L U H V D Q G S U R ¿ O H V K H H W V . 7 K H 6 $ 6 6 , - V available for purchase at the following site: https://ecom.mhs.com/(S(fyc3pvmieljp5vnkmkvepf45))/product.aspx?gr=cli&prod=sasi&id=overview

Texas Christian University Drug Dependence Screen V (TCUDS V)

The TCUDS V is a 17-item public domain instrument that was derived from a substance use diagnostic instrument (Brief Background Assessment–Drug-Related Problems section) developed by the Texas Christian University, Institute of Behavioral Research as part of an intake assessment for the Drug Abuse Treatment for AIDS-Risk Reduction (DATAR) project, a NIDA-funded initiative evaluating the effectiveness of new treatment intervention strategies (Simpson & Knight, 1998). The TCUDS V provides a self-report measure of substance use problems within the past 12 months, and is based on the DSM-5 criteria for substance use disorders. The instrument provides a brief screen for frequency of substance use, history of treatment, substance use disorder symptoms, and motivation for treatment. A cut-off score of > 4 on the TCUDS V indicates the presence of a moderate substance use disorder, and a score of > 6 indicates a severe disorder.

Positive Features

- The TCUDS V is brief to administer and can be easily administered and scored by nonclinicians, without significant training
- The TCUDS V has been revised to align with the DSM-5 diagnostic criteria for substance use disorders
- The TCUDS V is available at no cost
- The TCUDS is one of the most frequently used substance use screening instruments within state correctional systems (Moore & Mears, 2003; Peters et al., 2004)
- The TCUDS was found to be one of the most effective screening instruments in identifying inmates with severe substance use disorders in a study comparing the psychometric properties of several different screening instruments (Peters et al., 2000)
- The TCUDS had among the highest sensitivity (85 percent) and overall accuracy (82 percent) among several substance use screening instruments examined in a corrections-based study, and also has good specificity (78 percent; Peters et al., 2000)
- The TCUDS examines major DSM diagnostic symptoms of substance use disorders
- TCUDS scores of greater than 5 among prison inmates are associated with increased risk for recidivism (Baillargeon et al., 2009)
- The TCUDS is significantly correlated with the ASI (Pankow et al., 2012), supporting the convergent validity of the instrument
- Test-retest reliability of the TCUDS among incarcerated individuals is quite good (.89–.95; Knight, Simpson, & Morey, 2002; Peters et al., 2000)
- The TCUDS has good internal consistency in different correctional treatment settings

is reduced. Failure to detect mental disorders among offenders also leads to delay in triage to mental health services, behavioral problems that may be attributed to other causes, early dropout from substance use treatment, rapid cycling through community emergency services, and rearrest and reincarceration (Hiller et al., 2011). A wide range of mental health screens are available for use in the criminal justice system, including several that are in the public domain and downloadable from the internet. The following section describes mental health

of depression, including the Hamilton Rating Scale for Depression (HAM-D, r score = .71) and the Beck Hopelessness Scale (r score = .68)

- Among females offenders, the BDI-II shows good convergent validity with another measure of depression, the Beck Hopelessness scale (r score = .55). The instrument is also useful in predicting self-harm (Perry & Gilbody, 2009) and in identifying suicidal ideation (Kroner et al., 2011)
- The BDI-II provides a unidimensional construct of depression across cultures (Nuevo et al., 2009; Shafer, 2006), although it reviews several underlying components of depression (e.g., somatic, affective, and cognitive symptoms; Arnau et al., 2001; Dum et al., 2008; Steer, Ball, Ranieri, & Beck, 1999)
- Among people with substance use problems, the BDI-II exhibits good sensitivity (86–96 percent), specificity (86 percent), and negative predictive value (97 percent) in diagnosing depression (Scott et al., 2011; Seignourel, Green, & Schmitz, 2008). Previous studies examining the BDI also indicate moderately good sensitivity (67 percent) and specificity (69 percent) in diagnosing depression among individuals with alcohol problems (Willenbring, 1986)
- Several studies demonstrate high internal consistency within the BDI-II, including those examining female offenders, alpha=.90 (Kroner et al., 2009; Shafer, 2006), although

identify recommended cut-off scores for depression

- The factor structure of the BDI-II among prisoners is somewhat different than in the general population, suggesting that the instrument may measure other components of depression that are unique to offenders (Boothby & Durham, 1999)
- The BDI-II may have low specificity with substance-involved populations (Seignourel et al., 2008)
- The instrument should not be used as a sole indicator of depression but rather in conjunction with other instruments (Weiss & Mirin, 1989; Willenbring, 1986). Like other screening instruments, the BDI-II is not a diagnostic tool, and elevated scores do not necessarily reflect a major depressive disorder but rather the presence of depressed mood during the past 2 weeks
- Because the BDI measures subjective feelings of depression, it is difficult to discriminate between normal individuals who are experiencing sadness and those individuals who are clinically depressed (Hesselbrock, Hesselbrock, Tennen, Meyer, & Workman, 1983)
- The BDI-II does not differentiate among varying types of mood disorders (e.g., major depressive disorder and dysthymia; Richter, Werner, Heerlein, Kraus, & Sauer, 1998)
- Women score significantly higher than men on the BDI-II, but these gender differences are not reflected across age and racial/ethnic groups. Despite gender differences being acknowledged by the authors (Steer, Beck, & Brown, 1989), only a single set of interpretive guidelines is provided
- Definitions of depression and the experience of depression may differ across countries (Nuevo et al., 2009)
- An alternate version of the BDI-6 includes items (Beck et al., 1961; Bech, Gormsen, Loldrup, & Lunde, 2009) that are based on core features of the Hamilton Depression Scale (HAM-D), including depressed mood, guilt, work inhibition, difficulty making decisions, indecisiveness, irritability, and fatigue (Bech et al., 2009).

(Bland et al., 2012; Tatar, Kaasa & Cauffman, 2012; Scheyett et al., 2010). Among people with a history of incarceration, the CES-D is strongly correlated with other validated measures of depression (Bland et al., 2012; Tatar et al., 2012). The CES-D has good internal consistency when used with offenders (alphas=.71–.94; Bland et al., 2012; Tatar et al., 2012). The short form of the CES-D also demonstrates good internal consistency among offenders (Nyamathi et al., 2011)

- The CES-D has been used with substance-involved populations (Khosla, Juon, Kirk, Astemborski & Mehta., 2011; Perdue, Hagan, Thiede, & Valleroy, 2003) and has been found to be suitably effective in detecting symptoms of depression and in measuring change in these symptoms over time (Boyd & Hauenstein, 1997)
- The CES-D has been used with a variety of clinical and nonclinical populations (Atkins, Marin, Lo, Klann, & Hahlweg, 2010 ; Bakitas et al., 2009; Barnes & Meyer, 2012; Giese-Davis et al., 2011)
- The CES-D has been validated for use with different racial/ethnic groups and has been translated into several foreign languages
- The CES-D short forms show good psychometric properties across clinical and nonclinical populations and across gender, race/ethnicity, and different cultures (Al-Modallal, Abuidhail, Sowan, & Al-Rawashdeh, 2010; Carleton et al., 2013; Cheung & Bagley, 1998; Clark, Mahoney, Clark, & Eriksen, 2002; Cole, Rabin, Smith, & Kaufman, 2004; Kohut et al.,1993; Makambi et al., 2009; Milette, Hudson, Baron, & Thombs, 2010; Opoliner, Blacker, Fitzmaurice, & Becker, 2013; Radloff, 1977; Roberts, 1980; Santor & Coyne, 1997; Zhang et al., 2012). The CES-D is strongly correlated with other measures of depression such as the BDI (Cole et al., 2004; Zhang et al., 2012)
- The CES-D contains four factors (somatic, depressed affect, anhedonia, interpersonal problems) that are consistent across clinical and nonclinical populations, gender, and race/ethnicity (Bush, Novack, Schneider, & Madan, 2004; Makambi, Williams, Taylor, Rosenberg, Adams-Campbell., 2009; Shafer, 2006)
- The CES-D has good psychometric properties for use with adolescent and elderly populations (Dozema et al., 2011; Prescott et al., 1998; Sheehan, Fifield, Reisine, & Tennen, 1995; Wancata, Alexandrowicz, Marquart, Weiss, & Friedrich, 2006), and has sensitivity of 74–84 percent, and specificity of 60–74 percent (Haringsma, Engels, Beekman, & Spinhoven, 2004; Prescott et al., 1998)

Concerns

- Offenders and people with substance use disorders may exhibit elevated scores on the CES-D relative to other populations, which may warrant higher cut-off scores in screening for clinical depression (Bland et al., 2012; Khosla et al., 2011; Perdue et al., 2003; Tatar et al., 2012)
- Further validation in justice settings is needed to examine specificity and sensitivity in detecting depression
- The CES-D may be biased by gender (Stommel et al., 1993), and there may be differences in rates of depression by gender, even after accounting for measurement bias (Van de Velde; Bracke, Levecque, & Meuleman, 2010)
- The CES-D short form may contain two underlying factors of negative affect and lack of positive affect (Zhang et al., 2012)
- The CES-D has shown to have from two to four underlying factors across different populations (Al-Modallal et al., 2010; Carleton et al., 2013; Lee et al., 2008; Makambi et al., 2009; Shafer, 2006; Rivera-Medina, Caraballo, Rodriguez-Cordero, Bernal, & Dávila-Marrero, 2010)

Availability and Cost

The CES-D is available at no cost, and can be obtained at the following address: NIMH,

6001 Executive Blvd. Room 8184, MSC 9663, Bethesda, MD 20892-9663; (301) 443-4513. The instrument can also be downloaded at http://www.emcdda.europa.eu/html.cfm/index3634EN.html

General Screening Instruments for Mental Disorders

Brief Jail Mental Health Screen (BJMHS)

The BJMHS was developed through funding by the National Institute of Justice (NIJ) and was validated using a sample of over 10,000 detainees in four jails. The BJMHS was derived from the Referral Decision Scale (RDS), which was designed to aid correctional staff in identifying individuals who have severe mental disorders (Steadman, Scott, Osher, Agnese, & Robbins, 2005). In developing the screen, the total number of RDS items was reduced, several items were rephrased, and the assessed time span for symptom occurrence was changed from lifetime to the past 6 months. The BJMHS consists of six items that examine the occurrence of mental health symptoms for nine DSM-IV diagnoses, including mood disorders and psychotic disorders. The instrument includes two additional items that review prior hospitalization for mental health problems and current use of psychotropic medication. Individuals who endorse two or more items or who indicate either use of psychotropic medication or a history of prior psychiatric

2007; Meredith, Jaffe, Yanasak, Cherrier, & Saxon, 2007; Schwannauer & Chetwynd, 2007; Booth, Leukefeld, Falck, Wang, & Carlson, 2006)

Correctional Mental Health Screen (CMHS)

The Correctional Mental Health Screen (CMHS; Ford & Trestman, 2005) is a brief self-report screening tool for mental disorders in correctional settings. The CMHS was developed using a large correctional inmate sample that included men (N = 1,526) and women (N = 670). An original composite screening measure included 56 items that examined DSM-IV Axis I and II disorders. Separate screening versions were developed for male offenders (CMHS-M; 12 items) and female offenders (CMHS-F; 8 items) and consist of dichotomous (yes/no) items. Six items are

personality disorders (Steadman et al. 2005; Steadman et al., 2007)

- A key psychometric indicator, Area Under the Curve (AUC) is high for both the CMHS-M (73 percent) and CMHS-F (80 percent), indicating effective identification of mental disorders (Ford et al., 2009)
- The convergent validity of both the CMHS-F and CMHS-M is supported by strong correlations with indices of mental disorders from correctional records. Both forms of the CMHS also exhibit good discriminant validity and are not significantly correlated with non-mental health indicators (e.g., risk for violence, sex offending, education level; Ford et al., 2007)
- Interrater reliability for the CMHS-M and CMHS-F is quite high (Ford et al., 2007; 2009), with kappas for the CMHS-M ranging .66–1.0 and for the CMHS-F ranging .62–1.0
- Internal consistency for the CMHS-M (r score = .76) and CMHS-F (r score= .82) is also quite good (Ford et al., 2007, 2009)
- Test-retest reliability of the instrument was adequate across several studies (Ford et al., 2007; 2009) for both the CMHS-M (r score = .84) and the CMHS-F (r score = .82)

Concerns

- The CMHS-F exhibits lower sensitivity and specificity for mental disorders among female African American inmates at the cut-off score of 6. As a result, lower FXW RII VFRUHV DUH UHFRPPHQGHG H J • RU • WKDW LQFUHDVH VHQVLWLYLW\ ± percent), but yield rates of specificity that are relatively lower (29–71 percent) than those obtained for White female inmates. In general, the CMHS-F exhibits lower specificity for mental disorders than the BJMHS and the RDS
- Further validation is needed among offender subpopulations
- The false negative rate for mental disorders on the CMHS-M (18–26 percent) is higher than on the BJMHS (5–15 percent; Ford et al., 2007; Steadman et al., 2005)
- The CMHS-M has lower specificity in detecting anxiety disorders than other mental disorders (42 percent; Ford et al., 2007)

Availability and Cost

The CMHS-F and CMHS-M are available for download at no cost. The instruments and accompanying information regarding interpretation, validation, and scoring can be obtained at the following site: https://www.ncjrs.gov/pdffiles1/nij/216152.pdf

K6 and K10 Scales

The K6 and K10 scales were developed for the U.S. National Health Interview Survey to examine psychological distress (Kessler et al., 2003). The K6 is a 6-item screen that was derived from the 10-item K10, and evidence suggests that the K6 is as sensitive in detecting mental disorders as the K10. The six core domains of the screens are nervousness, hopelessness, restlessness, depression, feeling as though everything takes effort, and feelings of worthlessness. The K10 also addresses functional impairment related to mental disorders and examines whether psychiatric symptoms are attributable to medical problems. Both measures identify severe mental illness 60, ZKLFK LV GH¿QHG DV PHHWLQ diagnosis of one of the DSM-IV mood or anxiety GLVRUGHUV LQFOXVLYH RI VLJQL¿ impairment (Kessler et al., 2003). The K10 has been found to be somewhat more effective than the K6 in identifying anxiety and mood disorders (Furukawa, Kessler, Slade, & Andrews, 2003). Recommended K6 cut-off scores for identifying 60, LV • IRU RIIHQGHUV DQG • L population (Eno Louden et al., 2012; Kubiak, Beeble, & Bybee 2009; Kessler et al., 2002). The K10 is included in the National Comorbidity Survey Replication (NCS-R) and in the national surveys conducted by the WHO's World Mental Health initiative. The scales are available in both

interviewer-administered and self-administered forms.

Positive Features

- The K6 and K10 are available in the public domain
- The K6 and K10 are brief and can be easily administered and scored by nonclinicians. Guidelines for scoring and interpretation of the K6 and K10 are available
- The instruments have been translated into several languages and have been shown to have adequate sensitivity and specificity in correctly identifying mental disorders (Carrà et al., 2011)
- Although the K6 and K10 instruments were validated in a general health setting, studies indicate that the measures are useful in criminal justice settings (Swartz & Lurigio, 2005). Lower cut-off scores are used in offender populations in comparison to the general population
- A number of studies have examined the K6 for use with criminal justice populations, people with substance use disorders, and people who have co-occurring disorders and support the effectiveness of the K6/K10 scales with these populations (Hides et al., 2007; Kubiak et al., 2009; Kubiak, Kim, Fedock, & Bybee, 2013; Rush, Castel, Brands, Toneatto, & Veldhuizen, 2013; Swartz, 2008; Swartz & Lurigio, 2005; Swartz & Lurigio, 2006)
- The scales appear to accurately discriminate between individuals who meet criteria for a diagnosis of a mental disorder and those who do not, across large epidemiological samples inclusive of different cultures and age groups (Anderson et al., 2013; Andrews & Slade, 2001; Baggaley et al., 2007; Furukawa et al., 2003; Kessler et al., 2003; Kessler et al., 2010; Patel et al., 2008; Sakurai, Nishi, Kondo, Yanagida, & Kawakami, 2011)
- The K6 shows adequate sensitivity (76–86 percent) and specificity (65–75 percent) in detecting mental disorders among people with substance use disorders (Rush et al., 2013; Swartz & Lurigio 2006) and has similarly good psychometric properties for use with offenders (sensitivity = 62–76 percent; specificity = 86–90 percent) and across gender groups (Swartz, 2008; Eno Louden et al., 2012). The K6 has better sensitivity and specificity than other screening tools, such as the Addiction Severity Index and the Psychiatric Diagnostic Screening Questionnaire (PDSQ; Rush et al., 2013)
- Studies conducted in several different countries indicate that the K6 provides good results related to Area Under the Curve (AUC; 77–89 percent) in detecting mental disorders (Kessler et al., 2010)
- Psychometric properties of the K6 are both consistent and good across socio-demographic subsamples; cultures; and different populations, including offenders and people with substance use disorders (Andrews & Slade, 2001; Eno Louden et al., 2012; Furukawa et al., 2003; Kessler et al., 2002; Kessler et al., 2003; Kubiak et al., 2009; Patel et al., 2008; Rush et al., 2013; Sakurai et al., 2011; Slade, Johnston, Oakley-Browne, Andrews, & Whiteford, 2009; Swartz & Lurigio, 2006)
- The K10 has been used among juvenile offenders as an index of overall psychological distress (Kenny, Lennings, & Munn, 2008)

Concerns

- The K6 may not be as sensitive in detecting specific mental disorders in comparison to other mental health instruments, such as the CIDI (Composite International Diagnostic Interview) and the PHQ-9 (Patient Health Questionnaire), and is intended to identify the general presence of a serious mental disorder (Kessler et al., 2010)
- The K6 may have lower sensitivity in identifying mental disorders in comparison to the BJMHS when different cut-off scores are used. For example, among substance-involved samples, a cut-off score of 13 on

Availability and Cost

7KH 6&/ 5 FDQ EH SXUFKDVHG E\ TXDOL¿HG health care professionals from Pearson Assessments at the following site: http://www.pearsonclinical.com/psychology/products/100000645/symptom-checklist-90-revised-scl-90-r.html

7KH UHTXLUHG PDQXDO SUR¿OH IRUPV and answer sheets (50 sheets) cost approximately $132. Costs vary, depending on the desired formats.

Recommendations for Mental Health Screening Instruments

Information regarding screening instruments for mental disorders is based on a critical review of WKH OLWHUDWXUH DQG UHVHDUFK FRPSDULQJ WKH HI¿FDF\ of these instruments. Factors considered in UHFRPPHQGLQJ VSHFL¿F VFUHHQLQJ LQVWUXPHQWV include empirical evidence supporting the reliability and validity of the instrument, relative cost of the instrument, ease of administration, and previous use in the justice system. Although summaries of the instruments include research that was based on the DSM-IV criteria, recommendations are made considering the degree to which instruments align closely with the new DSM-5 criteria and that allow for a more seamless WUDQVLWLRQ WR WKH QHZ FODVVL¿FDWLRQ V\VWHP Recommended instruments for screening mental disorders are those that address co-occurring PHQWDO KHDOWK LVVXHV DQG DUH JHDUHG VSHFL¿FDOO\ towards the criminal justice system. Based on the literature review and these considerations, the following screening instruments are recommended to examine mental disorders:

1. Either the Correctional Mental Health Screen (CMHS-F; CMHS-M)

(or)

2. The Mental Health Screening Form-III (MHSF-III) to address mental health problems

(or)

3. The Brief Jail Mental Health Screen.

Each of these instruments requires approximately 5–10 minutes to administer and score.

Screening Instruments for Co-occurring Mental and Substance Use Disorders

Several screening instruments have been developed that address both mental and substance use disorders. These screening instruments differ in the scope and depth of coverage of co-occurring disorders ani.x3/d 9960 >>lents have been the literett0 ><</MCre co-occurring

residential treatment, community mental health patients, and primary health care patients (Cameron et al., 2007)

- The Spanish version of the BASIS-24 shows good convergent validity, because the summary score is significantly correlated with other self-reported measures of mental health (Eisen et al., 2010). The BASIS-24 subscales of depressive functioning, psychotic symptoms, and alcohol/drug use also show significant differences between those who are diagnosed with and without these disorders in an inpatient psychiatric sample. The Spanish version of the BASIS-24 also has good discriminant validity for psychotic and self-harm symptoms (Eisen et al., 2010)
- Statistical analysis indicates a good fit for the six BASIS-24 subscales among inpatient and outpatient samples, and across ethnic groups (Eisen et al., 2006, 2010)
- The BASIS-24 and its subscales have good internal consistency across racial/ethnic groups, clinical psychiatric populations, primary care populations , and general populations (alphas > .70; Cameron et al., 2007; Eisen et al., 2006; Kertz et al., 2012; Livingston et al., 2011)

Concerns

- The BASIS instruments have not been extensively examined within criminal justice settings
- The measure was originally designed to assess treatment outcomes and to increase consumer involvement in care, and not necessarily for diagnostic purposes
- The BASIS-32 impulsivity, substance abuse, and psychotic symptoms scales may not be sensitive to change over time (Russo et al., 1997; Trauer & Tobias, 2004)
- The BASIS-24 subscales and summary score may not effectively distinguish between inpatients and outpatients among African American and Latino populations, as no significant differences in scores were found between these treatment populations. The BASIS subscales of emotional lability may not be able to distinguish between those with and without bipolar disorder for these same racial/ethnic groups, across inpatient and outpatient settings (Eisen et al., 2006)
- The Spanish version of the BASIS-24 may have poor discriminant validity for subscales of emotional lability and interpersonal relationships (Eisen et al., 2010)
- The BASIS-24 demonstrates poorer test-retest reliability for inpatient samples, particularly on subscales related to interpersonal relationships, emotional lability, and alcohol/drug use, as indicated by intraclass correlation coefficients (ICCs) of .43–.89 (Eisen et al., 2010)

Availability and Cost

The BASIS-24 instrument is available from McLean Hospital at the following site: http://www.ebasis.org/basis24.php

The cost of the BASIS-24 is based on the number of sites licensed to use the instrument. There is an DQQXDO IHH RI IRU WKH ¿UVW V second site, and $50 for the third site.

Staff at McLean Hospital can also be contacted for information regarding the BASIS-24 at spereda@mcleanpo.mclean.org or (617) 855-2424.

The BASIS-32 instrument can be downloaded free of charge at the following site, but materials do not include interpretation or scoring information: http://infotechsoft.com/products/aspect_forms.aspx?formID=BASIS-32

Centre for Addiction and Mental Health–Concurrent Disorders Screener (CAMH-CDS)

The CAMH-CDS is a computer-administered questionnaire that screens for 11 mental disorders, including substance use disorders. The instrument was developed to provide a brief assessment

for co-occurring disorders and is designed to determine whether DSM diagnostic criteria are likely to be met for both current and past disorders. The CAMH-CDS requires 5–20 minutes to administer, depending on the number of disorders reported. The instrument was validated using three large substance use treatment-seeking samples.

Positive Features

- The CAMH-CDS requires only minimal mental health training to administer
- Test results can be generated by computer, immediately following administration
- The CAMHS-CDS has good sensitivity (86–92 percent) in identifying mental disorders for a variety of populations. For mood disorders, anxiety disorders, and schizophrenia/schizoaffective disorders, the CAMH-CDS exhibits good sensitivity (78–80 percent) and adequate specificity (56–68 percent; Negrete, Collins, Turner, & Skinner, 2004)
- The CAMH-CDS has excellent test-retest reliability for mood disorder and anxiety disorder modules and has moderately good reliability for the schizophrenia module (kappas range .72–.94; Negrete et al., 2004)

Concerns

- The CAMH-CDS has only limited ability to discriminate among different mental disorders
- Although the instrument has a high level of sensitivity in detecting mental disorders, it has significantly lower specificity (40–74 percent) in both double blind and clinical samples. For example, with disorders and symptom presentations such as mania, bipolar disorder–mania, and schizoaffective mania, the CAMH-CDS exhibits relatively low sensitivity (57–62 percent; Negrete et al., 2004). Using the previous DSM multi-axial system, the CAMH-CDS often does not effectively discriminate between mental disorders and personality disorders
- The criterion measure for validating the instrument was an unstructured clinical evaluation conducted by a group of trained psychiatrists who were asked to indicate whether, in their clinical judgment, certain disorders were present within 2 weeks of the administration of the CAMH-CDS
- The CAMH-CDS has not been widely used or tested with criminal justice populations
- Interrater reliability may be lower for

mood, anxiety, and psychotic disorders, and 37–57 percent of participants were referred for further assessment. Similar results have been obtained for different gender and race/ethnicity groups (Alexander et al., 2008). In a study involving participants in family assistance programs, the MMS exhibited adequate specificity (63–86 percent) and sensitivity (61–96 percent) at cut-off scores of 6–12, with overall accuracy ranging 76–77 percent for SCID-I diagnoses and 43–58 percent for referral to treatment (Alexander, Layman, & Haugland, 2013)

- The MMS was found to have higher sensitivity and specificity than other screens, such as the Brief Jail Mental Health Screen (BJMHS) and the K-6 (improved sensitivity only over the K-6; Alexander et al., 2008)
- Among offenders, the MINI-M or MMS demonstrates good sensitivity (71 percent) at a cut-off score of 5, with overall accuracy of 69 percent for any mental disorder as indexed by the SCID-I (Sacks et al., 2007b). Findings are similar across gender groups. For severe mental disorders (schizophrenia, major depression, and bipolar disorder) identified by the SCID-I, at a cut-off score of 10, the MMS/MINI-M exhibits adequate specificity (84 percent) and overall accuracy (70 percent; Sacks et al., 2007b). The MMS has good internal consistency (alphas = .90–.92), and interrater reliability is quite good (92 percent). Test-retest reliability over a period of 1 week was found to be quite high (Alexander et al., 2008, 2013)

Concerns

- Further validation of the MINI-M is needed in offender populations for screening mental disorders
- In comparison to clinical interviews, use of the MINI results in more frequent diagnosis of co-occurring disorders (Black, Arndt, Hale, & Rogerson, 2004)
- The MINI-Screen includes only one question related to alcohol use and one question examining drug use. The instrument does not include an interval measure of frequency or quantity of substance use
- The MINI-M/MMS appears to exhibit poor specificity for any mental disorder (61 percent) at a cut-off score of 5, as determined by the SCID-I, and has poor sensitivity (42 percent) in detecting severe mental disorders at a cut-off score of 10 (Sacks et al., 2007b)

Availability and Cost

The MINI-Screen can be obtained from the developers' website as part of the entire MINI package, inclusive of the MINI-Screen. The package can be purchased as paper instruments or as electronic computer-administered instruments. A licensing permission form for use of the MINI and MINI-Screen is provided. There is a one-time processing cost of $19.95. This cost is for individual use by students or private clinical practices. If an organization purchases the MINI package inclusive of the MINI-Screen, price varies based on number of uses. For instance, at the time of this writing, 25 administrations is $125.

The MINI package that includes the MINI-Screen can be obtained at the following site: http://www.medical-outcomes.com/index/mini

7KH 0RGL¿HG 0,1, 6FUHHQ FDQ EH G
at no cost at the following site, which includes instructions for scoring and interpretation: http://www.oasas.ny.gov/treatment/COD/documents/MMSTool.pdf

Psychiatric Diagnostic Screening Questionnaire (PDSQ)

The Psychiatric Diagnostic Screening Questionnaire (PDSQ) is a 126-item self-administered instrument that can be used for screening and diagnosis of mental disorders (e.g., mood disorders, anxiety disorders, psychotic disorders) and substance use disorders. The PDSQ provides separate subscales for alcohol

The cost to purchase the PDSQ is $136.50 for 25 test booklets, 25 summary sheets, an instruction manual, and a CD containing 13 follow-up interview guides (one for each of 13 disorders).

Screening and Assessment Instruments for Suicide Risk

Recommendations for CODs Screening Instruments

Information describing screening instruments that address both mental and substance use disorders (CODs) is based on a critical evaluation of available instruments and a review of research FRPSDULQJ WKH HI¿FDF\ RI WKHVH VFUHHQHUV .H\ factors used in comparing the instruments include empirical evidence supporting both the reliability and validity of the instrument, relative cost of the instrument, ease of administration within the criminal justice settings, and previous use and evidence of effectiveness within the criminal justice system. Although validity indices for screens described in this section are typically based on previous versions of the DSM (e.g., DSM-IV), recommendations regarding instruments are predicated on their alignment with the recently developed DSM-5, allowing for a more seamless transition from DSM-IV to DSM-5. The following is a recommended screening instrument that addresses both mental and substance use disorders:

- The MINI-Screen addresses a range of co-occurring mental and substance use problems. The MINI-Screen requires approximately 15 minutes to administer and score

In addition, separate screening instruments for mental and substance use disorders can be used in combination. The Brief Jail Mental Health Screen (BJMHS) or the Correctional Mental Health Screen (CMHS-F/CMHS-M) can be combined with the Texas Christian University Drug Screen V (TCUDS V). Refer to the sections "Screening Instruments for Mental Disorders" and "Screening Instrument for Substance Use Disorders" for descriptions and availability information.

other measures of suicidal ideation, including the BSS, the Suicide Probability Scale (SPS), the BHS, the Beck Depression Inventory (BDI), and the Beck Anxiety Inventory (BAI; Bisconer & Gross, 2007)

- Among psychiatric outpatients, the ASIQ items load highly on a factor related to suicidal ideation, as measured by a composite variable of the ASIQ and the Inventory of Depression and Anxiety Scales (IDAS), supporting the convergent validity of the instrument (Naragon-Gainey & Watson, 2011)
- The ASIQ distinguishes between those at risk for suicide and "controls" in a psychiatric sample (Bisconer & Gross, 2007)
- The ASIQ is able to discriminate between those with and without a history of suicide attempts in a psychiatric sample (Osman et al.,1999)
- The ASIQ predicts suicide attempts during a 3 month follow-up period among psychiatric patients who have previously attempted suicide, supporting the predictive validity of the instrument (Osman et al., 1999)
- The ASIQ's area under the curve (AUC) in identifying multiple suicide attempters is quite good (AUC = .80 total scale; AUC = .69 for critical items; Horon et al., 2013)
- The instrument's specificity is quite good in psychiatric samples (78 percent) when compared with historical records of suicidal ideation and behaviors (Bisconer & Gross, 2007)
-

Positive Features

- The BSS is brief to administer and score
- The BSS has been used with offenders (Horon et al., 2013; Kroner et al., 2011; Lohner, & Konrad, 2006; Palmer & Connelly, 2005; Senior et al., 2007; Way, Kaufman, Knoll, & Chlebowski, 2013)
- Among offenders who have CODs, the BSS has good convergent validity with other measures of suicide risk, including the ASIQ, RASQ, and the SRAC (Horon et al., 2013)
- The BSS and the BSS screening items are able to discriminate between multiple attempters and non-attempters or single attempters and are able to more effectively predict multiple suicide attempts in comparison to other measures of suicide risk, including the ASIQ and RASQ (Horon et al., 2013)
- Among offenders, the BSS is related to other indices of suicide, including suicidal ideation, suicidal thoughts, and past suicide attempts, as measured by the Depression Hopelessness Suicide Screening form, providing support for its convergent validity (Kroner et al., 2011)
- BSS scores for current suicidal ideation among offenders reporting multiple suicide attempts is significantly higher than for those with only one reported suicide attempt, supporting the validity of the BSS among offenders who have mental health problems (Way et al., 2013)
- The BSS area under the curve (AUC) is quite good (.74) as is the AUC for the BSS screening items (.71), in classifying people who have multiple prior suicide attempts (Horon et al., 2013)
- Studies involving several international offender populations provide support for the convergent and concurrent validity of the BSS (Lohner & Konrad, 2006; Senior et al., 2007)
- Among veterans, the BSS is able to distinguish between those with and without suicidal ideation. The instrument also detects higher rates of suicidal ideation among veterans who have CODs in comparison to those who have mental disorders only, supporting the validity of the BSS (Bahraini et al., 2013). The BSS demonstrates good internal consistency among offenders (alpha = .85; Horon et al., 2013) and has high levels of internal consistency (alpha = .84), temporal stability, and predictive validity when used to make decisions about hospital admissions (Beck, Brown, & Steer, 1997)
- The BSS has better specificity and positive predictive value in identifying suicide risk than the BHS and the BDI (Cochrane-Brink, Lofchy, & Sakinofsky, 2000)
- A computerized version of the BSS is available. In a study comparing computerized self-report, pen and paper self-report, and clinician report, both self-report versions of the BSI correlated highly (r score > .90) with the clinician reports (Beck, Steer, & Ranieri, 1988)

Concerns

- The BSS is not a public domain instrument
- Additional research is needed to determine the psychometric properties of the BSS with offenders who have CODs. The BSS may not be related to prior suicide attempts in some criminal justice samples (Way et al., 2013)
- Mean scores on the computerized self-reported measure are higher than the clinical ratings, indicating that this measure may yield elevated levels of suicidal ideation (Beck et al., 1988)
- Caution should be taken when interpreting BSS suicide risk severity scores, as offenders may not be willing to report suicidal ideation and may underreport the true severity of suicidal thoughts and desires (Way et al., 2013)
- Analysis of the BSS among clinical samples indicates that it may consist of two to four factors (Beck et al., 1997;

Beck, Weissman, Lester, & Trexler, 1976; Witte et al., 2006; Kingsbury, 1993; Spirito, Sterling, Donaldson, & Arrigan, 1996). Several studies indicate a three-factor solution but provide ambiguous results about the nature of the factors (Beck, Kovacks, & Weissman, 1979; Steer, Rissmiller, Ranieri, & Beck, 1993). Thus, caution should be exercised when interpreting BSS scores

Availability and Cost

The BSS is commercially available and can be purchased from the Pearson Assessment website:

feelings of burdensomeness, supporting the construct validity of the INQ among people who have mental disorders (Davidson, Wingate, Grant, Judah, & Mils, 2011)

- The two-factor structure of the INQ (feelings of burdensomeness, lack of belonging) is supported by a study involving a military sample (Bryan, 2011)
- Internal consistency of the INQ and ACSS is quite good, with alphas for the INQ ranging .83–.94 and alphas for the ACSS ranging .83–.85 (Bryan et al., 2012; Nademin et al., 2008)

Concerns

- As noted previously, there has been little research examining the INQ/ACSS with offender populations
- The INQ/ACSS does not yield a threshold or cutoff score indicating high risk for suicide
- For young adults who report suicidal ideation, the interaction of feelings of burdensomeness and lack of belonging does not predict suicide attempts, thus introducing concern about the validity in using the INQ/ACSS with this population (Joiner et al., 2009)
- In a military sample, suicide capability is related to lack of belonging but not feelings of burdensomeness, suicidality scores, or symptoms of depression. Thus, suicide capability should not be used as an independent measure to predict risk of suicide with this population (Bryan, Cukrowicz, West, & Morrow, 2010)

Availability and Cost

The INQ/ACSS is a public domain instrument and is available at the following site: http://psy.fsu.edu/~joinerlab/measures/ACSS-FAD.pdf

Cukrowicz, K. C., Wingate, L. R., Driscoll, K. A., & Joiner Jr, T. E. (2004). A standard of care for the assessment of suicide risk and associated treatment: The Florida State University Psychology Clinic as an example. Journal of Contemporary Psychotherapy, 34(1), 87–100. http://link.springer.com/article/10.1023/B:JOCP.0000010915.77490.71

Recommendations for Suicide Risk Screening Instruments

Information describing suicide screening instruments is based on a critical review of the existing literature. Key areas considered in making recommendations about suicide screens include empirical evidence supporting the reliability and validity of instruments, the relative costs of instruments, ease of administration, use within the criminal justice system, and alignment with theoretical frameworks that have been established for assessment of suicide risk. As noted previously, offenders who are screened DV KDYLQJ VLJQL¿FDQW VXLFLGH LGHDWLRQ VKRXOG EH immediately referred for further assessment to determine the need for treatment, close supervision, and other services.

For brief suicide screening, the following instruments are recommended:

1. The Interpersonal Needs Questionnaire (INQ) coupled with the Acquired Capability for Suicide Scale (ACSS). The INQ/ACSS was developed based on the Suicide Risk 'HFLVLRQ 7UHH DQG PHDVXUHV VSHFLILFDOO\ associated with suicide risk, including suicidal desire (feelings of burdensomeness, lack of belonging) and capability.

(or)

2. The Beck Scale for Suicide Ideation (BSS).

(or)

3. TheAdult Suicidal Ideation Questionnaire (ASIQ).

The BSS and ASIQ assess some, but not all components of the prevailing suicide risk assessment framework, but both instruments have been examined within the criminal justice system, and have been found to reliably predict suicide risk.

Each of the previously described instruments requires between 10–15 minutes to administer and score.

If additional time is available to provide a more detailed assessment of suicide risk, the following instrument is recommended:

- The Suicide Risk Decision Tree (SRDT), a clinician-administered interview that provides a comprehensive assessment of environmental and psychosocial factors associated with suicide risk. The SRDT examines factors that are fully aligned with the theoretical framework for suicide risk assessment, and its open-ended response format facilitates additional interviewer probes to follow up on specific

The SRDT interview requires approximately 20 minutes to administer.

In contrasting the recommended suicide risk instruments, considerations should include the cost of these instruments. The BSS and ASIQ are commercially available and are more expensive to administer than the INQ/ACSS instruments, which are available in the public domain. However, the validity of the INQ/ACSS has not been determined within criminal justice settings. Although the Suicide Risk Decision Tree (SRDT) interview provides broader coverage of suicide risk factors, it requires additional time to administer.

Screening and Diagnostic Instruments for Trauma and PTSD

People with CODs have very high rates of trauma and posttraumatic stress disorder (PTSD) in comparison to the general population, and these rates are augmented in the criminal justice system (Elbogen et al., 2012; Lynch et al., 2013; Proctor,

2012; Proctor & Hoffmann, 2012; Steadman et al., 2013). Trauma is often overlooked in screening within the criminal justice system, particularly in substance use treatment settings. Failure to identify trauma within this population often leads to poor treatment outcomes (Prendergast, 2009; Ruiz, Douglas, Edens, Nikolova, & Lilienfeld, 2012; Steadman et al., 2013). Several specialized screening and assessment instruments have been developed to examine the history of trauma and PTSD, which may be useful within criminal justice settings. Several other general mental health screening and assessment instruments that also examine trauma and PTSD (e.g., CMHS, MINI, PAI, SCID-IV) are described in previous sections of this monograph. Screens for trauma and PTSD are generally brief, noninvasive, and do not require administration by a mental health professional. Two types of screening instruments are available: (1) those that address stressful life events and their effects, and (2) those that address severity of symptoms based on DSM criteria. The diagnostic screens are somewhat longer to administer but provide a formal diagnosis of PTSD and are often used as follow-ups to brief screens. As mentioned previously, screening for trauma/PTSD can be conducted by nonclinicians through use of standardized self-report instruments, which require minimal training. However, all staff who administer trauma screens should be fully aware of appropriate referral sources and the nature of trauma-related services. Offenders who screen positive for trauma and PTSD should receive a thorough assessment by a trained and licensed certified mental health professional.

Changes to the DSM-5 Diagnostic Criteria for PTSD

There are several major differences between the DSM-IV criteria for PTSD and the more recent DSM-5 criteria (APA, 2013). The DSM-IV defined PTSD with the following criteria: A[2]—traumatic event experienced, including severity, frequency, and intensity; B—re-experiencing traumatic events; C—avoidance of trauma; and D—hyperarousal. Criterion E assessed duration of traumatic symptoms and Criterion F assessed related functional impairment. Under DSM-5, PTSD is included in a new section, entitled, "Trauma and Stress-related Disorders." Criterion A now explicitly addresses sexual violation as a traumatic event and includes reoccurring exposure to traumatic events, such as those faced by law enforcement or paramedics. Moreover, Criterion A no longer requires a response of intense fear, helplessness, or horror. A new Criterion D ("negative cognitions and mood") has been added to capture symptoms related to distorted thinking and negative emotions. These symptoms were originally addressed in DSM-IV Criterion C. The new criterion includes items aimed at assessing persistent feelings of blame (self or others), detachment from others, anhedonia (inability to experience pleasure) and dissociative amnesia for traumatic events. Criterion E ("alterations in arousal") now examines changes in arousal and reactivity. Items include irritability and anger, reckless or impulsive behaviors, hypervigilance, related functional impairment. Under DSM-

and questions inquire about symptoms experienced over the past 7 days. The cut-off score for the

of translated versions of the IES-R is also quite good (alphas range .83–.91; Weiss & Marmar, 2004)

- The test-retest reliability of the IES-R is quite good (r scores range .89–.94) over a 6-month period (Weiss & Marmar, 1996). Test-retest reliability of translated versions of the IES-R is also good (r scores range .52–.86; Weiss & Marmar, 2004)

Concerns

- Instructions must be provided to respondents for IES-R questions that ask about specific traumatic events
- The IES-R does not provide a diagnosis of PTSD and instead provides an evaluation of avoidance and intrusive symptoms

experiences, and as such the PCL-C may also have utility for the veteran population. The PCL-C queries about symptoms related to traumatic life events and can be used with various SRSXODWLRQV 7KH 3&/ 6SHFL¿F 3&/ 6 TXHULHV DERXW V\PSWRPV UHODWHG WR D VSHFL¿F WUDXPDWLF OLIH HYHQW 6\PSWRPV LGHQWL¿HG E\ WKH 3&/ FDQ refer to one or more traumas experienced. Prior to administering the PCL, it is important to screen respondents for Criterion A of DSM criteria for PTSD or the experience of an actual stressor involving actual or threatened death, serious injury to self or others, or actual or threatened sexual violence. The PCL requires approximately 10 minutes to administer. Respondents are asked to rate the severity of symptoms, according to "how much you have been bothered by the problem" during the past month, on a 1–5 scale. Total V\PSWRP VHYHULW\ LV UHÀHFWHG LQ WKH VXPPHG VFRUH of the 17 PCL items. Thresholds for symptom severity include ratings of 3 or above on criterion B (re-experiencing symptoms, questions 1–5), 3 or above on Criterion C (avoidance of symptoms, questions 6–12), and 2 or above on Criterion D (hyperarousal, questions 13–17). Suggested cut-off scores for the PCL are 30–35 in community samples, 36–44 in medical clinics (e.g., VA primary care), and 45–50 in mental health settings (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). The TCU Mental Trauma and PTSD Screen (TCU TRMAForm) is a version of the PCL used with offenders that is available from the Texas Christian University Institute of Behavioral Research.

ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp

The TCU Mental Trauma and PTSD Screen (TCU TRMAForm) can be downloaded at no cost at the following site:http://ibr.tcu.edu/forms/client-%20health-and-social-risk-forms/

Primary Care PTSD Screen (PC-PTSD)

The PC-PTSD (Prins et al., 2003) is a four-item screen for PTSD in primary care settings. The PC-PTSD examines several symptoms of PTSD, including re-experiencing a traumatic event, emotional numbing, avoidance, and hyperarousal. Instructions query about traumatic experiences in the past month. The cut-off for indicating WKH SUHVHQFH RI 376' LV D VFUHHQ responses. The PC-PTSD has variable cut-off scores, depending on the base rates of PTSD in different populations. Maximizing sensitivity over VSHFL¿FLW\ LV SUHIHUUHG LQ FOLQLFDO VHWWLQJV EQ RUGHU to minimize false negatives, which can prove to be more costly in the diagnostic process (Calhoun et al., 2010). In using the PC-PTSD for screening of PTSD among those with CODs and in determining diagnoses, it is important to consider overlapping mental health and substance problems and their relationship with PTSD symptoms. People screened as positive on the instrument should receive further clinician-administered assessment related to PTSD.

Positive Features

- The PC-PTSD is widely used in VA primary care settings (U.S. Department of Veterans Affairs [VA], 2004; VA/Department of Defense, 2003)
- The PC-PTSD is designed for those with an eighth-grade reading level or higher
- The PC-PTSD has been used in various criminal justice settings (Ford, Chang, Levine, & Zhang, 2012; Ford & Trestman, 2005; Ford et al., 2007), including veteran treatment courts (Slattery et al., 2013)
- The Correctional Mental Health Screen (CMHS) has adapted items from the PC-PTSD (Ford & Trestman, 2005; Ford et al., 2007) to screen for PTSD in criminal justice settings
- Among those enrolled in substance use treatment, the PC-PTSD demonstrates acceptable sensitivity (67 percent) and specificity (72 percent) relative to a SCID-IV PTSD diagnosis (van Dam, Ehring, Vedel, & Emmelkamp, 2010)
- In primary care settings, as compared to the CAPS, the PC-PTSD shows good diagnostic accuracy at a cut-off score of 3, indicated by the AUC (92 percent), in addition to good sensitivity (85 percent), specificity (82 percent), and negative predictive value (98 percent; Freedy et al., 2010). Using a cut-off score of 3 in military primary care settings (Hoge, Engel, Freed, Liu, & Armstrong, 2008), the PC-PTSD shows good sensitivity (70 percent), specificity (92 percent), and negative predictive value (97 percent) relative to the Posttraumatic Symptom Scale Interview (PSS-I, Foa et al., 1993)
- Among veterans, the PC-PTSD shows good sensitivity (83 percent), specificity (85 percent), and overall diagnostic accuracy (85 percent) at a cut-off score of 3, as determined by the SCID-IV for PTSD (Calhoun et al., 2010)
- At a cut-off score of 2 in a sample of veterans in primary care settings (Ouimette, Wade, Prins & Schohn, 2008), the PC-PTSD has higher specificity (96 percent) and overall diagnostic accuracy (93 percent) than the General Health Questionnaire (GHQ-12; Goldberg & Williams, 1988) and provides greater predictive validity than the GHQ in identifying PTSD
- Item response theory (IRT) analyses indicate that the PC-PTSD performs consistently well in screening for PTSD across gender groups (Oliver, 2013)
- The test-retest reliability of the PC-PTSD is quite good in primary care settings (r score = .83; Prins et al., 2003)

- The TSC-40 has good test-retest reliability, as demonstrated by significant correlations between baseline and 3-month follow-up scores across subscales (r scores range .50–.56)
- The TSC-40 total score has excellent internal consistency (Elliot & Briere, 1992; alpha = .90), as do the sleep disturbances (alpha = .77) and sexual problems (alpha = .73) scales. Other studies show similar results, with alphas ranging .66–.77 for the subscales; and alphas for the total score ranging .89–.91 (Briere, Elliott, Harris, & Cotman, 1995)

Concerns

- The psychometric properties of the TSC-40 have not been widely examined in criminal justice settings
- The TSC-40 was primarily designed for research purposes
- The TSC-40 may not be as comprehensive in scope as the TSI
- The TSC-40 does not examine traumatic life events that are experienced but rather associated posttraumatic distress and general psychological distress

Availability and Cost

The TSC-40 is a public domain instrument and can be downloaded at no cost at the following site, which also provides information regarding scoring and administration: http://bhpr.hrsa.gov/grants/areahealtheducationcenters/ta/Files percent20for percent20Veterans percent20Mental percent20Health percent20CE/traumachecklist.pdf

The Trauma Symptom Inventory (TSI)

The TSI is a 100-item self-report inventory that evaluates the presence of acute and chronic trauma symptoms. The instrument requires approximately 20 minutes to administer. The TSI contains 10 clinical scales that examine affective, cognitive, and physical issues related to trauma. Clinical scales include the following: Anxious Arousal (AA), Depression (D), Anger/Irritability (AI), Intrusive Experiences (IE), Defensive Avoidance (DA), Dissociation (DIS), Sexual Concerns (SC), Dysfunctional Sexual Behavior (DSB), Impaired Self-Reference (ISR), and Tension Reduction Behavior (TRB). Three validity scales are included to detect efforts to either underreport or exaggerate symptoms. These include Atypical Responses (ATR), Response Level (RL), and Inconsistent Responding (INC). Items are based on the DSM-IV symptom criteria for PTSD. Respondents rate the frequency of each symptom experienced on a four-point scale.

Separate TSI norms are available for men and women, as well as for different age groups. There is an 86-item alternative version (TSI-A) that does not examine sexual concerns or dysfunctional sexual behavior scales. A revised version of the TSI is also available (TSI-2; Briere, 2010), which provides improved validity scales for detecting malingering or feigned PTSD symptoms. The TSI-2 contains 136 items, two validity scales, 12 clinical scales, 12 subscales, and four factors. The TSI-2 was normed on a large U.S. sample. Additional clinical scales include Insecure Attachment (IA), Somatic Preoccupations (SOM), and Suicidality (SUI). The instrument provides a voidance

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populations (Adams et al, 2011; Najavits, & Walsh, 2012)

- The TSI contains three validity scales designed to detect the level, typicality, and consistency of responses (Briere, 1995)
- The ATR validity scale is effective in detecting feigned PTSD symptoms across race/ethnicity groups (Briere, 2010)
- Scores on the sexual concerns scale of the TSI are correlated with longer stay in substance use treatment among women (Adams et al., 2011)
- In a community sample of people (McDevitt-Murphy, Weather, & Adkins, 2005) reporting a traumatic event, TSI clinical scales are moderately to strongly correlated with relevant cluster symptoms of the CAPS. For example, the Intrusive Experiences scale is correlated with Cluster B symptoms of re-experiencing trauma on the CAPS (r score = .59). The TSI clinical scales also are positively correlated with other measures of convergent validity, including the IES- R (r scores range .36–.68), the PCL (r scores range .32–.65), the Civilian Mississippi Scale (CMS; r scores range .36– 66), and the Anxiety-Related Disorders Scale (ARD-T) on the Personality Assessment Inventory (PAI, r scores range .35–.73). This same study found that the TSI demonstrates good diagnostic accuracy across subscales, as determined by the CAPS, with sensitivity ranging 63–94 percent and specificity ranging 59–91 percent. Cut-off scores were DV IROORZV 'HIHQVH $YRLGDQFH 7 • $Q[LRXV $URXVDO 7 • 'HSUHVVLRQ 7 • $W\SLFDO 5HVSRQVH 7 • DQG ,QWUXVLYH ([SHULHQFHV 7 •
- Among undergraduates instructed to feign PTSD symptoms, the Atypical Response Scale was able to accurately detect malingering as determined by the Personality Assessment Inventory (PAI) Negative Impression Management scale (NIM). At a cut-off score of 7, the TSI ATR scale accurately classifies 74 percent (sensitivity) of malingerers, and 77 percent (specificity) of those experiencing "true" PTSD distress, with an overall correct classification rate of 75 percent (Briere, 2010)
- The internal consistency of the TSI across subscales is quite good (alphas range .84–.97) in community, clinical, and domestic violence samples (Kaysen et al., 2007), among undergraduate students (Burns, Jackson, & Harding, 2010), and in military samples (Briere, 1995)
- The TSI has good internal consistency (alphas range .74–.90) and good sensitivity (91 percent) and specificity (92 percent; Briere, 1995)

Concerns

- Psychometric properties of the TSI have not been established in criminal justice settings
- The TSI is not a public domain instrument and is somewhat costly
- Advanced clinical training is recommended for staff assigned to interpret TSI test results

among females who have CODs (McHugo et al., 2005)

Concerns

- The psychometric properties of the LSC-R have not been established in criminal justice settings
- The ability of the LSC-R to predict PTSD has not been widely studied
- The LSC-R describes other stressful life events that may not meet Criterion DSM-IV A1 for PTSD

Availability and Cost

qMC 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40

- The SLESQ-R may not provide broad coverage of all traumatic events included in criterion A1, thus potentially under-identifying those with PTSD symptoms (Long et al., 2008)
- Estimates of reliability and validity of the SLESQ-R were established with undergraduate students and not with diverse populations
- There may be differences in the reliability of reported traumatic events on the self-report and interview versions of the SLESQ. Specifically, under-reporting of events such as experienced child sexual/physical abuse may occur on the self-report version of the instrument (Green et al., 1998)
- The SLESQ can misidentify "true" traumatic events among low-income minority respondents (Green et al., 2006). For example, robbery, being threatened with a weapon, and attempted rape are sometimes identified by the SLESQ as stressors rather than as "true" traumatic events. However, miscarriage, abortion, emotional abuse, substance use, and eating disorders are sometimes identified as "true" traumatic events experienced but are not classified as traumatic events by the SLESQ. Therefore the SLESQ may not accurately identify "true" traumatic events experienced by minorities, leading to potential under-diagnosis of PTSD
- Test-retest reliability in undergraduate students may be lower for life threatening events, attempted sexual assault, and "other" traumatic events, as indicated by kappas lower than .60 (Green et al., 1998)

Availability and Cost

The SLESQ-R is a public domain instrument and can be downloaded without charge at the following site: http://ctc.georgetown.edu/toolkit. Direct link to the SLESQ-R form: https://georgetown.app.box.com/s/nzprmm2bn5pwzdw1l62w

Alternatively, the measure can be requested by e-mailing the developer of the measure, Dr. Lisa A. Goodman, at goodmalc@bc.edu

Information describing the SLESQ-R can be found at the following site http://www.ptsd.va.gov/professional/assessment/te-measures/stress-life-events.asp

Trauma History Questionnaire (THQ)

The THQ (Green, 1996) is a 24-item self-report measure that examines traumatic events within different categories. The categories include crime-related events (items 1–4, e.g., robbery), general disaster (items 5–17, e.g., accidents involving injury to self/death of others, military trauma, natural disaster), and physical/sexual experiences (items 18–24, e.g., physical attacks, sexual assaults). Respondents are asked to indicate if they were exposed to the event, if it occurred repeatedly, the age at which it occurred, and the frequency of the event. The THQ requires approximately 10–15 minutes to complete. The THQ can be provided in an interview and requires approximately 15–20 minutes to administer. Positive endorsement of items should be followed up with a more formal assessment of PTSD symptoms.

Positive Features

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- Offenders who receive psychiatric services have higher rates of traumatic events on the THQ, particularly for physical and sexual abuse, in comparison to non-offender psychiatric patients (Sarkar et al., 2005)
- One study of the THQ found that all offenders were exposed to at least one traumatic event prior to committing an offense (Payne, Watt, Rogers, & McMurran, 2008)
- Female offenders determined by the THQ to have been exposed to interpersonal violence show significant levels of PTSD symptoms, as indicated by the PCL; general psychiatric distress, as indicated by the BSI; and recent substance use. Repeated interpersonal violence identified by the THQ predicts PTSD symptoms and general psychiatric distress (Lynch et al., 2012)
- According to the THQ, female offenders with polysubstance use disorders report higher rates of exposure to trauma in comparison to people with single types of substance use problems, supporting the concurrent validity of the instrument (Salgado et al., 2007)
- The convergent validity of the THQ with the SLESQ is quite good, with kappas for individual items ranging .61–1.00 in a large sample of depressed low-income women (Goodman et al., 1998). Similarly, the THQ exhibits significant correlations with a measure of exposure to conflict, the Conflict Tactics Scale (r score = .46), in a sample of battered women (Humphreys, Lee, Neylan, & Marmar, 1999)
- Supporting the predictive validity of the instrument among inpatient and outpatients who have severe mental disorders, the frequency of trauma events identified by the THQ predicts PTSD symptoms, as determined by the PCL (Mueser et al., 1998). In a law enforcement sample, the THQ contributes unique variance in predicting PTSD symptoms (Lilly, Pole, Best, Metzler, & Marmar, 2009). Other studies also show that the THQ is related to PTSD symptoms (Golier et al., 2003; Green, Krupnick et al., 2000; Najavits et al., 1998; Spertus, Yehuda, Wong, Halligan, & Seremetis, 2003) and depression (Spertus, Burns, Glenn, Lofland, & McCracken, 1999, Spertus et al., 2003)
- Test-retest reliability of the THQ over a 2-week interval ranges from acceptable to excellent (kappas = .57–.82; Mueser et al., 2001) across traumatic events reported by psychiatric inpatients. Similarly, interrater reliability is quite good (kappas = .76–1.00) across reported traumatic events (Mueser et al., 2001)
- Test-retest reliability of the THQ among college students is adequate over a 2–3 month period (r scores range .51–.90) across events (Green, Goodman et al., 2000; Green et al., 2005)

Concerns

- As with other trauma screens, the THQ should not be used as a stand-alone instrument in diagnosing PTSD and rather should be used in combination with other instruments that examine symptom severity
- It may be difficult to identify traumatic events as defined by PTSD Criterion A, as the THQ does not explicitly examine the newly revised DSM-5 PTSD Criterion A
- Respondents may underreport, overreport, or distort traumatic events, contributing to lower validity and reliability of the measure (Hooper, Stockton, Krupnick, & Green, 2011)
- The reliability of the THQ can be compromised during repeated administrations if the respondent reports the same traumatic event under a different category (Hooper et al., 2011)
- Test-retest reliability of the THQ for general events (e.g., other serious injury or other unwanted sexual incident) may be somewhat low (r score = .47; Hooper et al., 2011)

distress or impairment. Symptom cluster severity scores are generated by summing severity scores for items corresponding to a particular DSM-5 cluster. It is recommended that questions related to Criterion A are supplemented by administration of the Life Events Checklist for DSM-5 (LEC-5), which examines lifetime exposure to 16 events, and any other event that may potentially cause trauma and PTSD. The CAPS requires 45–60 minutes to administer. Scoring and interpretation guidelines are included in the CAPS-5.

As mentioned previously, instructions for the CAPS-5 recommend administering the LEC-5 (or another structured screen that reviews past traumatic life events) in advance of inquiring about specific symptoms that might be PTSD. The LEC-5 is a 17-item instrument that can be administered via self-report or interview. An extended self-report version is available to identify the "worst" event (if there was more than one) that occurred during the designated time period. The interview version of the LEC-5 provides this same information, and helps to determine whether Criterion A for PTSD has been met.

Positive Features

- The CAPS is considered to be the "gold standard" for diagnosing PTSD
- The CAPS assesses current and past symptoms of PTSD
- The CAPS provides explicit anchors and behavioral referents to guide ratings
- In forensic settings, the CAPS is recommended for assessment of PTSD symptoms and diagnosis (Huang, Zhang, Momartin, Cao, & Zhao, 2006; Keane, Buckley, & Miller, 2003; Zlotnick, Najavits, Rohsenow, & Johnson, 2003; Zlotnick et al., 2009)
- The CAPS has been translated into Bosnian, Chinese, French, German, and Swedish
- The instrument has been used with diverse populations, including people who have mental and substance use disorders
- The CAPS has been used with offenders (Spitzer et al., 2001; Trestman, Ford, Zhang, & Wiesbrock, 2007)
- The CAPS has demonstrated excellent psychometric properties (convergent, discriminant, diagnostic validity, and sensitivity to clinical change) among clinical and research populations (Weathers, Keane, & Davidson, 2001)
- Relevant scales of the PCL are highly correlated with the CAPS (r scores range .58–.74), supporting the convergent validity of the CAPS (Palmieri, Weathers, Difede, & King, 2007). Additionally, in support of the concurrent validity of the CAPS, PTSD severity among veterans is higher for those with a history of arrest, depression, and substance use (Calhoun, Malesky, Bosworth, & Beckham, 2005)
- In clinical and nonclinical samples, the CAPS demonstrates high agreement with the Posttraumatic Stress Scale-Interview (PSS-I) for diagnosis of PTSD, when

.92–1.00), intensity ratings (kappas range .93–.98), and global severity ratings (r score =.89)

- Internal consistency is quite good for frequency (alphas range .63–.85), intensity (alphas range .71–.81), and total score (alpha = .94; Mueser et al., 2001) among people who have severe mental disorders. Similar results were found among clinical and nonclinical samples, with alphas ranging .71–.88 (Foa & Tolin, 2000)
- Test-retest reliability of the CAPS over a 2-week interval among people with severe mental disorders is acceptable (kappa = .63; Mueser et al., 2001) and at a severity score R I • U H O L D E L O L W \ L V K L J K H U N D S S D

Concerns

- The CAPS is quite lengthy to administer
- A significant amount of training is required to conduct CAPS interviews
- The CAPS is designed for research purposes and may not be ideally suited for routine use in clinical settings
- The psychometric properties of the CAPS have not been widely studied in criminal justice settings
- The intensity ratings for individual PTSD symptoms may be difficult to ascertain from the range of symptoms identified
- Scoring rules for diagnosis of PTSD using the CAPS may vary by definition (see Blanchard et al., 1995; Weathers, Ruscio, & Keane, 1999), and liberal versus stringent scoring criteria can result in different rates of PTSD diagnosis, and inconsistencies in diagnostic agreement between the CAPS and other interview measures of PTSD (PSS-I; Foa & Tolin, 2000)

Availability and Cost

The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) is a public domain instrument that can be obtained at no cost via an online request form at the following site: http://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp

Information regarding scoring of the CAPS-5 is available at the same website. In the past, a CAPS training manual and a CAPS training CD could be obtained from the National Center for PTSD, operated by the U.S. Department of Veterans Affairs.

The Life Events Checklist for DSM-5 (LEC-5) is a public domain instrument and is available for download at the following site: http://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp

Posttraumatic Stress Diagnostic Scale (PDS)

The PDS (Foa, 1996) is a 49-item self-report measure that assesses severity (Criterion B, C, and D) of PTSD symptoms related to a traumatic event. Items assess all DSM-IV criteria for PTSD. Current (past month) PTSD is addressed and instructions can be adapted for other time frames (e.g., lifetime). The PDS addresses traumatic events experienced (Criterion A), duration of symptoms (Criterion E), and functional impairment (Criterion F). There are four sections of the PDS, including (1) a trauma checklist; (2) description of traumatic events provided by the respondent, with queries for injuries, serious threats to life, helplessness, and terror; (3) assessment of 17 DSM-IV PTSD symptoms; and 4) functional impairment. Total severity scores on the PDS range 0–51. The recommended F X W R II V F R U H I R U G L D J Q R V L V R I 3 S U R ¿ O H U H S R U W F D Q E H J H Q H U D W H diagnosis, symptom frequency, symptom severity, and level of functional impairment. The PDS can be used for screening of PTSD symptoms and for diagnosis of PTSD.

Positive Features

- The PDS is highly recommended for assessment of PTSD symptoms (Keane, Silberbogen, & Weierich, 2008)
- The PDS is a commonly used tool among the International Society for Traumatic Stress Studies (ISTSS; Elhai et al., 2005)

- The PDS has been used with offenders (Harner, Budescu, Gillihan, Riley, & Foa 2013; Messina, Grella, Cartier, & Torres 2010; Sacks et al., 2008)
- Concurrent validity of the PDS is quite good (Foa, Cashman, Jaycox & Perry, 1997), as demonstrated by strong correlations with the State-Trait Anxiety Inventory (STAI) and the IES-R
- The PDS demonstrates good diagnostic accuracy, with overall accuracy ranging 82–88 percent. At a cut-off score of 27, the PDS also has acceptable sensitivity (67–89 percent), specificity (75–91 percent), and negative predictive value (86–96 percent) among psychiatric outpatients and those seeking treatment for PTSD, in addition to those who are at high risk for trauma (Foa et al., 1997; Sheeran & Zimmerman, 2002)
- Among sexual assault survivors, drinking problems to cope with PTSD symptoms is a significant predictor of severity scores on the PDS (Ullman, Filipias, Townsend, & Starzynski, 2006). Moreover, severity scores on the PDS are significantly correlated with alcohol problems as measured by the MAST (Ullman, Filipias, Townsend, & Starzynski, 2005)
- The PDS shows high internal consistency across domains (alphas range .78–.92; Foa et al., 1997)
- Test-retest reliability of the PDS is quite good for diagnosis (kappa = .74) and severity scores (r scores range .77–.85) among those endorsing a traumatic experience (Foa et al., 1997)

Concerns

- The PDS has not been extensively studied in adult criminal justice settings
- The PDS may overdiagnose PTSD, as indicated by high rates of "false positives" among a sample of domestic violence survivors (Griffin, Uhlmansiek, Resick, & Mechanic, 2004). Thus, caution should be exercised when interpreting PDS scores among certain populations (Keane et al., 2008)
- The PDS is highly correlated with the BDI, and as such, the instrument may not provide adequate discriminant validity in distinguishing between depressive symptoms and PTSD (Foa et al., 1997; Norris & Hamblen, 2004)
- The self-report nature of the PDS may detract from its validity in diagnosing PTSD

Availability and Cost

The PDS starter kit costs approximately $60, which includes the PDS manual, test booklet, three answer sheets, and three administrations using Q software.

A hand-scoring starter kit costs approximately $67, which contains an administration manual, a test booklet, 10 answer sheets, 10 scoring worksheets, and a scoring instruction sheet.

Prices for scoring software vary according to the frequency of administration.

The PDS was discontinued; however, paper-based inventory will be sold until supplies run out. Information describing how to obtain the PDS can be found at the following site: http://psychcorp.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=PAg510&Mode=summary

Posttraumatic Symptom Scale–Interview Version (PSS-I)

The PSS-I is a semi-structured interview that provides both diagnosis of PTSD and assessment of PTSD symptom severity. The PSS-I includes 17 items that assess DSM-IV PTSD symptoms related to re-experiencing (items 1–5), avoidance (items 6–12), and hyperarousal (items 13–17). Items inquire about frequency and severity. Scoring is calculated by summing items within each domain, and a total score is obtained by summing all 17 items across domains. A diagnosis is made based on achieving a score of "2" or more

in each domain. The PSS-I asks about current PTSD symptoms (past month or past 2 weeks). The PSS-I requires approximately 15–25 minutes to administer.

Positive Features

- The PSS-I is a brief semi-structured interview that performs as well as the CAPS in assessing PTSD and is briefer to administer (International Society for Traumatic Stress Studies, 2013)
- The PSS-I has been used successfully among people who have severe mental disorders (Brunet, Birchwood, Upthegrove, Michail, & Ross, 2012; O'Hare, Sherrer, & Shen, 2006), offenders (Sacks, McKendrick, & Hamilton, 2012), people with substance use problems (Foa & Williams, 2010; Reynolds et al., 2005), those with co-occurring PTSD and substance use disorders (Foa & Williams, 2010; Riggs, Rukstalis, Volpicelli, Kalmanson, & Foa, 2003), and in community samples (Bedard-Gilligan, Jaeger, Echiverri-Cohen, & Zoellner, 2012; O'Hare, Sherrer, Yeamen & Cutler, 2009)
- The diagnostic accuracy of the PSS-I is quite good in clinical and nonclinical samples (Foa & Tolin, 2000), with sensitivity ranging 71–86 percent and specificity ranging 78–100 percent for different scoring approaches (Blanchard et al., 1995; Weathers et al., 1999). An earlier study reports similarly high rates of sensitivity (.97; Foa et al., 1993)
- Agreement between the PSS-I and CAPS diagnoses of PTSD ranges 70–86 percent in clinical and nonclinical samples (Foa & Tolin, 2000)
- Convergent validity for the PSS-I among clinical and nonclinical samples is good, as evidenced by strong correlations with the CAPS and its domains (r scores range .63–.87; Foa & Tolin, 2000). Moreover, the correlations between the PSS-I and the SCID module for PTSD are equivalent to those between the CAPS and the SCID
- Among people who have severe mental disorders, subjective distress as indicated by the PSS-I is related to high risk behaviors, including drinking and attempted suicide (O'Hare et al., 2006)
- In support of the PSS-I's concurrent validity, among those with substance use and mental disorders, people diagnosed with PTSD using the PSS-I have significantly higher scores on the Addiction Severity Index for medical problems and higher rates of psychoticism, as measured by the Brief Symptom Inventory (Reynolds et al., 2005)
- The internal consistency of the PSS-I is quite good (alphas range .65–.86) in clinical and nonclinical samples (Foa & Tolin, 2000)
- The PSS-I has good interrater reliability across domains, with agreement ranging 94–99 percent (Foa et al., 2005; Foa & Tolin, 2000). An earlier study reported similar results (kappa = .91; Foa et al., 1993)

Concerns

- The PSS-I has not been studied extensively in criminal justice settings
- The generalizability of the PSS-I to a range of clinical settings has not yet been established
- Test-retest reliability of the PSS-I has not been widely examinedestablished

F R P S D U L Q J W K H H I ¿ F D F \ R I W K H V H L Q V W U X P H Q W V
) D F W R U V F R Q V L G H U H G L Q U H F R P P H Q G L Q J V S H F L ¿ F
instruments include empirical evidence supporting the reliability and validity of the instrument, relative cost of the instrument, ease of administration, and use in the justice system. Although summaries of the instruments included

such as understanding the rules of conduct and treatment goals (Goethals et al., 2012)

- Treatment motivation as indexed by the CMR is directly related to treatment alliance, treatment participation, and treatment outcomes (Melnick et al., 2001)
- The CMRS is useful in predicting 30-day retention in long-term TC treatment in the community (DeLeon et al., 1994)
- Young (2002) found that external factors measured by the Circumstances scale of the CMRS predicted 90-day retention of criminal justice clients in community-based residential treatment programs, while the Readiness scale of the CMRS predicted 180-day retention
- Melnick et al. (1997) found that age was significantly correlated with scores on the CMRS and that the instrument successfully predicted short-term retention rates in TC treatment across age groups
- DeLeon, Melnick, Kressel, and Jainchill (1994) found that CMRS scales are more effective predictors of 30-day and 10-month treatment retention than a range of demographic and background variables, including legal status
- People mismatched to treatment in the DATOS had significantly lower CMR treatment motivation scores at baseline in comparison to those who were properly matched to treatment (DeLeon et al., 2010)
- Higher motivation for mental health treatment as indexed by the CMR predicts greater adherence to treatment among psychiatric patients (Magura, Mateu, Rosenblum, Matusow, & Fong, 2014)
- The CMR has good predictive utility for treatment outcomes across race and ethnicity (DeLeon, Melnick, Schoket, & Jainchill, 1993)
- Reliability of the CMRS total score as measured by Cronbach's alpha is .84 (Melnick et al., 2001), and reliabilities for individual scale scores range from .53 for the Circumstances scale to .84 for the Readiness scale
- The CMRS has good internal consistency (alphas = .84–.87; .67–.83; DeLeon et al., 1994; Goethals et al., 2012, Melnick, 1999)

Concerns

- CMRS scores vary significantly for offenders of differing intellectual functioning (Van de Velde, Broekaert, Schuyten, & Van Hove, 2005)
- The CMRS items are related to TCs, and thus, the instrument may not generalize to other treatment settings for assessing circumstances, motivation, and readiness for change (Groshkova, 2010; Zemore & Ajzen, 2014)
- The validity of the CMRS has not been examined among individuals with CODs
- The CMRS has not been thoroughly evaluated to determine its usefulness in predicting retention in jail or community-based offender treatment programs
- Circumstances scale scores have low reliability (Van de Velde et al., 2005)
- The Circumstances scale may consist of two factors, Pressures to Enter Treatment, and Pressures to Leave Treatment (DeLeon et al., 2000), thus explaining difficulties related to low reliability. Caution should be used when interpreting this scale

Availability and Cost

The CMRS manual and instruments can be obtained free of charge at the following site: http://www.emcdda.europa.eu/html.cfm/index3597EN.html

Readiness for Change Questionnaire (RCQ)

The RCQ (Rollnick, Heather, Gold, & Hall, 1992) is a 12-item measure based on the transtheoretical "stages-of-change" model, developed by Prochaska and DiClemente (1992). The instrument was originally developed to LGHQWLI\ VSHFL¿F VWDJHV RI FKDQ drinkers who are not seeking treatment, but it has been used far more broadly among a range

of substance-involved populations. The RCQ-CV (clinician's version) consists of three scales, Pre-contemplation, Contemplation, and Action, each consisting of four items. Item responses are provided on a 5-point scale, ranging from "strongly agree" to "strongly disagree," with higher scores on the RCQ representing greater willingness to change. The 15-item RTCQ-TV (treatment version) was designed for individuals in treatment or who are seeking treatment (Share, McCrady, & Epstein, 2004) and is used to determine the level of readiness to engage in treatment and to assist in treatment planning. A revised 12-item version of the RTCQ-TV is also available (Heather & Honekopp, 2008). Both the RCQ-CV and RTCQ-TV take approximately 2–3 minutes to administer, are designed for both adolescents and adults, and are available in the public domain. The RCQ has been adapted to measure readiness to change in other areas, such as violent behavior, criminal behaviors, and anger problems. Neither instrument requires training to administer or score.

Positive Features

- The RCQ is brief to administer
- The self-administered format of the RCQ is advantageous for use in hospital and other settings in which there is limited time to compile information (Rollnick et al., 1992). The RCQ has been used with several offender populations (Casey, Day, Howells, & Ward, 2007; Day et al., 2009; McMurran et al., 1998; Watt, Shepherd, & Newcombe, 2008) and with people with substance use disorders (Freeman et al., 2005; Heather, Luce, Peck, Dunbar, & James, 1999; Gregoire, & Burke, 2004; Share, McCrady, & Epstein, 2004; Wells-Parker, Kenne, Spratke, & Williams, 2000)
- The RCQ has been adapted for use with offenders (Readiness to Change Offending, RCOQ) to address motivation to change criminal behaviors (McMurran et al., 1998)
- The RCQ is related to a newly developed offender instrument that examines readiness for change, the Corrections Victoria Treatment Readiness Questionnaire (CVTR), and demonstrates moderate to strong correlations with the CVTR scales (Casey et al., 2007)
- The RCQ has been adapted to measure readiness to change violent behaviors among offenders and is correlated with another treatment readiness scale, the Violence Treatment Readiness Questionnaire (VTRQ; Day et al., 2009)
- Convergent validity of the RCQ among people involved in substance use treatment is supported by correlations with another well-validated measure of readiness for change, the URICA (r scores range .39–.56; Heather et al., 1999)
- Violent offenders who received no intervention were more likely to be in the pre-contemplation stage for changing drinking behaviors compared to those receiving a treatment intervention, supporting the validity of the RCQ in assessing readiness for change (Watt et al., 2008)
- Convergent validity of the instrument is also indicated among people with substance use disorders, in which RCQ scores indicating pre-contemplation, contemplation, and action stages are related to scores from the URICA, another well-validated measure of readiness for change (Napper et al., 2008)
- Support for the concurrent validity of the RCQ is provided among a substance-involved sample, in which people scoring in the pre-contemplation range showed significantly more injection drug use relative to those in the action stage. People scoring in the pre-contemplation range also remained in treatment for fewer weeks than those scoring in the contemplation range (Napper et al., 2008)
- People who had received substance use treatment were more likely to receive RCQ scores in the action stage. Moreover, those who had better treatment outcomes were more likely to be in the action or

contemplation stage compared with those who had poor treatment outcomes, supporting the validity of the measure for assessing readiness for change (Heather et al., 1999)

- The RCQ's validity is supported among a sample of offenders who were court-mandated to outpatient substance use treatment because they were more likely to be in the action or contemplation stage compared to those not receiving treatment, even after controlling for level of substance use problems (Gregoire & Burke, 2004)
- In a sample of repeat DUI offenders, those determined to be in the contemplation stage by the RCQ for changing level of alcohol consumption had higher self-efficacy for controlling their drinking and had lower levels of alcohol consumption relative to those in the pre-contemplation stage (Freeman et al., 2005). Another study (Wells-Parker et al., 2000) indicates that those determined to be in the action stage by the RCQ for reducing drinking and driving behaviors have lower rates of criminal recidivism. These studies support the concurrent validity of the RCQ instrument
- Several other studies demonstrate the discriminant and convergent validity of the RCQ in measuring readiness for change among DUI offenders (Freeman et al., 2005; Wells-Parker & Williams, 2002)
- The RCQ has good predictive validity for changes in drinking behavior over time (Share, McCrady, & Epstein, 2004)
- The revised RCQ-TV shows a good fit with a three-factor structure, supporting the three scales of the RCQ-TV (Heather & Honekopp, 2008)
- The revised RCQ-TV total scale score shows good internal consistency (alpha > .70), particularly for the Action scale (alpha = .85; Heather & Honekopp, 2008). Previous studies indicated that the RCQ has satisfactory internal consistency, with Cronbach's alphas of .73 for the Pre-contemplation subscale, .80 for the Contemplation scale, .85 for the Action scale (Rollnick et al., 1992; Napper et al., 2008), and .71 for the entire scale (Day et al., 2009)
- Test-retest reliability for the RCQ scales has been found to be satisfactory (Rollnick et al., 1992), with correlations of .82 (Pre-contemplation), .86 (Contemplation), and .78 (Action). Test-retest reliability of the RCQ among those enrolled in substance use treatment is quite good over a 3-day interval (r scores range .69–.86 across RCQ scales; Heather et al., 1999). Good test-retest reliability of the revised RCQ-TV has also been demonstrated among people enrolled in alcohol treatment (r scores range .76–.88) for all stages of change, over a 3-month interval (Heather & Honekopp, 2008)

Concerns

- The validity of the RCQ has not been widely studied among offenders and additional research on its psychometric properties among this population is needed
- Little evidence has been found to support concordance between interviewer-determined stage of change and stage of change assessed by the RCQ (kappas range .08–.45; Addington, El-Guebaly, Duchak, & Hodgins, 1999)
- The internal consistency of the RCQ may be somewhat low (alpha = .69; Casey et al., 2007), particularly for the Pre-contemplation scale (alpha = .68; Napper et al., 2008) and the Contemplation scale (alpha = .60–65; Heather et al., 1999; Napper et al., 2008)
- The revised RCQ-TV shows low internal consistency for the Pre-contemplation (alpha = .66) and Contemplation scales (alpha = .66; Heather & Honekopp, 2008)
- The RCQ (McMurran et al., 1998) shows low internal consistency for the Pre-contemplation (alpha = .60) and Contemplation (alpha = .49) scales

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can detract from effective assignment of individuals to different stages of change. The determination of stages of change by the SOCRATES is not always consistent with stages of change determined by other measures, such as by the RCQ (Burrowes & Needs, 2009; Lechner, Brug, De Vries, van Assesma, & Muddle, 1998; Littell & Girvin, 2002; Williamson, Day, Howells, Bubner, & Jauncey, 2003)

- The SOCRATES may not be able to clearly distinguish among the five stages of change (DiClemente, Schlundt, & Gemmell, 2004)
- Although a study conducted by Nochajski and Stasiewicz (2005) did not support the use of the SOCRATES with DUI offenders, the Ambivalence and Recognition subscales were found to be associated with binge drinking
- The SOCRATES 19-item version may not detect changes in motivation among drug-involved offenders who received a motivational interviewing intervention, as well as the RCQ (Vanderburg, 2003)
- Not all subscales of the SOCRATES may be useful in predicting treatment retention. For example, the Ambivalence and Taking Steps scales were not found to predict length of stay in treatment among offenders (Brocato & Wagner, 2008)
- The SOCRATES may be more useful when used in combination with the URICA to assess readiness to change (DiClemente et al., 2004)
- In a review of the existing literature, DiClemente, Schlundt, and Gemmell (2004) found only modest support for the predictive validity of the SOCRATES
- Research provides support for both two- and three-factor structures for the SOCRATES (Demmel, Beck, Richter, & Reker 2004; Figlie, Dunn, & Laranjeira, 2005; Mitchell et al., 2005) and indicates that the number of items could be reduced
- The internal consistency of the SOCRATES is low when used to determine readiness for change via stages of change (Hodgins,

- The TCU MOTForm was developed for use in criminal justice settings
- A greater desire for help (DH) as measured by the TCU MOTForm is related to greater treatment participation (Joe, Simpson, Greener, & Rowan-Szal, 1999)
- Treatment readiness (TR) as measured by the TCU MOTForm is related to improved post-treatment outcomes (Joe, Simpson, Greener et al., 1999; Simpson, Joe, Greener, & Rowan-Szal, 2000)
- Among offender and community-based treatment samples, the TCU MOTForm scales of PR, DH, and TR are correlated with treatment engagement, satisfaction, counselor rapport, and peer support (Joe, Simpson, & Broom, 1999; Pankow et al., 2012; Simpson et al., 2000; Simpson et al., 2012). The DH, TR, and TN scales also predict significant variance in treatment participation, supporting the predictive validity of the scales (Simpson et al., 2012)
- Across gender groups among offender samples, people with higher scores on the TCU MOTForm have higher levels of treatment participation, supporting the validity of the measure (Simpson et al., 2012)
- Across prison and community-based treatment settings, the TCU MOTForm scales are related to scales from the Addiction Severity Index (ASI). Specifically, the PR, DH, and TN scales are positively related to higher scores on the psychiatric, medical, legal, drug, alcohol, and employment scales of the ASI, supporting the concurrent validity of the TCU MOTForm (Pankow et al., 2012)
- Among offenders, higher scores on the TCU MOTForm (particularly the DH, TR, and TN scales) are negatively correlated with criminal thinking scales such as power orientation, coldheartedness, criminal rationalization, and entitlement (Garner, Knight, Flynn, Morey, & Simpson, 2007), supporting the concurrent validity of the TCU MOTForm
- An exploratory factor analysis of the

University of Rhode Island Change Assessment Scale (URICA)

The URICA (DiClemente & Hughes, 1990; McConnaughy, Prochaska, & Velicer, 1983) includes 24-, 28-, and 32-item versions of the self-report questionnaire examining motivation and readiness for treatment. The 32-item URICA consists of four scales made up of 8 items each, while the 28-item and the 24-item versions have four scales consisting of 7 and 6 items, respectively. The 24-item version has been adapted to those with CODs (URICA-M). The URICA-M uses simple language and is presented in a manner that is understandable to the respondent, and can be administered as an interview for those who have problems related to literacy or sight. A 12-item version of the URICA is available that examines readiness to change drinking behaviors and includes four scales. The four scales were developed to examine each of the theoretical stages of change (Pre-contemplation, Contemplation, Action, and Maintenance) related to individual motivation for treatment (DiClemente & Prochaska 1982, 1985; Prochaska & DiClemente, 1992).

The URICA appears to identify two distinctive subtypes: pre-contemplation and contemplation/action (Blanchard, Morgenstern, Morgan, Labouvie, & Bux, 2003; Edens & Willoughby, 1999, 2000). Readiness to change (RTC) can be calculated from the URICA instrument by subtracting mean Pre-contemplation scores from Contemplation, Action, and Maintenance scores (Connors et al., 2000; Project MATCH Research Group, 1997). A Contemplative Action score (CA) can be calculated by subtracting mean Contemplation scores from Action scores (Pantalon, Nich, Frankforter, & Carroll, 2002). The following cut-off scores may be appropriate for the general population as "Preparers into Action Takers." URICA scale scores may vary across different settings and stages of change in the particular settings.

Thus, use of the URICA to classify individuals to various stages of change should consider profiles generated from the particular setting correspond with stages of change in that setting. The URICA differs from the SOCRATES and several other motivational screens in that it does not directly ask about motivation for alcohol or drug treatment but instead presents questions in a more general manner. The URICA does not require clinical training to administer or score.

Positive Features

- The URICA is brief to administer and score
- The URICA has been used with offender populations (Alexander & Morris, 2008; Brodeur, Rondeau, Brochu, Lindsay, & Phelps 2008; Levesque, Gelles, & Velicer, 2000; Polaschek, Anstiss, & Wilson, 2010; Tierney & McCabe, 2004), people with substance use disorders (Callaghan et al., 2008; Budney, Higgins, Radnovich, & Novy, 2000; Budney, Moore, Rocha, & Higgins, 2006; Field, Adinoff, Harris, Ball, & Carroll, 2009; Jungerman, Andreoni, & Laranjeira, 2007), and those with CODs (Bellack et al., 2006; Kinnaman, Bellack, Brown, & Yang, 2007; Nidecker, DiClemente, Bennett, & Bellack, 2008)
- The URICA has been adapted for domestic violence offenders (URICA-DV), and the instrument properties are consistent with the original URICA four-scale model. The URICA-DV shows good psychometric properties and is correlated with domestic violence behaviors such as history of violence, blame, and changing violent behaviors (Levesque et al., 2000)
- The URICA-DV demonstrates good concurrent validity (Alexander & Morris, 2008) such that those determined to be in later stages of change (higher scores on contemplation, action and maintenance) report less psychological aggression against their partner during the previous 6 months
- The URICA's validity in assessing readiness for change is demonstrated in outpatient substance use treatment

settings (Field, Duncan, Washington, & Adinoff, 2007), where RTC scores are correlated with increased anger problems and experience of recent life stressors, suggesting that RTC reflects the desire to change and seek help. In these settings, CA scores are negatively correlated with alcohol problems and anxiety, indicating that CA may reflect commitment to change substance use behaviors. Three studies involving outpatient substance use treatment participants (Budney et al., 2000; Budney et al., 2006; Jungerman et al., 2007) found that URICA scores were negatively correlated with marijuana use and related problems after treatment, supporting the concurrent validity of the URICA (Callaghan et al., 2008)

- Support for the convergent and concurrent validity of the URICA has been shown in outpatient treatment settings, in which higher RTC scores are correlated with more severe drug and alcohol problems (Field et al., 2009), while higher CA scores are associated with less severe alcohol and drug use problems and less severe familial and medical problems (Field et al., 2009)
- The validity of the URICA has also been demonstrated among people with CODs. Among this population, higher psychiatric distress is correlated with endorsement of negative aspects of drinking and higher scores on the Maintenance scale of the URICA, indicating greater difficulties in attempts to maintain sobriety (Velasquez, Carbonari, & DiClemente, 1999)
- In support of the convergent validity of the URICA among people who have CODs, the URICA-M is correlated with other measures of change, such as the Process of Change Scale (POC; DiClemente, Carbonari, Addy, & Velazquez, 1996) and its subscales and the “cons” of drug use from the Decisional Balance Scale (DBS; Velicer, DiClemente, Prochaska, & Brandenburg, 1985). The relationship between the POC and the URICA-M are strongest among depressed individuals (Nidecker et al., 2008)
- The URICA is able to discriminate between readiness to change among people who are alcohol dependent, with and without co-occurring depression (Shields & Hufford, 2005)
- The concurrent and convergent validity of the URICA in predicting change in criminal behaviors among offenders is supported by high correlations (r score = .80) with the Criminogenic Needs Inventory (CNI; Coebergh, Bakker, Anstiss, Maynard, & Percy, 2001) and low correlations (r score = -.42) with an inventory of deceptive behaviors, the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1998; Polaschek et al., 2010)
- The URICA has good psychometric properties in predicting change in criminal behaviors (Field et al.,2009; Tierney & McCabe, 2004; Polaschek et al., 2010)
- The URICA-M demonstrates good psychometric properties as a unitary scale among those with CODs (Nidecker et al., 2008), as the Pre-contemplation scale is negatively correlated with other scales (-.25 to -.30), while Contemplation, Action, and Maintenance scales are positively correlated with each other (r scores range .48–.80)
- The URICA has good internal consistency among people with CODs (Pantalon & Swanson, 2003). When applied to changing criminal behavior among offenders, internal consistency is acceptable for the 32-item URICA (alpha = .82) and across scales of Pre-contemplation (alpha = .75–.83), Contemplation (alpha = .60–90), Action (alpha =.81–.93), and Maintenance (alpha =.89–.90; Polaschek et al., 2010; Tierney & McCabe, 2004). Internal consistency of the URICA is also good when applied to changing substance use behaviors, for scales of Pre-contemplation (alphas range .73–.80), Contemplation (alphas range .72–.90), Action (alphas range .71–.81), and Maintenance (alphas

range .67–.74; Field et al., 2009; Nidecker et al., 2008)

- The URICA has good reliability, with estimates ranging .79–.88 (Carey, Purine, Maisto, & Carey, 1999). Reliability estimates for the URICA are .68–.85 among alcohol, opiate, cocaine, and nicotine-dependent individuals (Blanchard et al., 2003)

Concerns

- Additional research is needed to establish the validity of the URICA with offenders
- Among people with CODs, the URICA may not predict levels of treatment participation, treatment retention, dropout, or other treatment outcomes (Bellack et al., 2006; Kinnaman et al., 2007)
- Research examining the validity of the URICA has yielded mixed results. Studies involving people with alcohol user disorders and psychotherapy clients provide support for the validity of the URICA's four scales, but studies involving people with other drug use disorders do not provide similarly strong support (Carey et al., 1999; DiClemente et al., 2004)
- Although good concurrent validity was found for the four URICA scales and for the overall score, one study found that neither the scales, nor the overall score successfully predicted treatment outcome (Blanchard et al., 2003)
- The URICA produces scores related to four stages of change. However, these aren't precisely aligned with the most recent transtheoretical model of change (Prochaska et al., 1992), in which the Preparation stage has been eliminated due to poor fit with the instrument's underlying factor structure (Polaschek et al., 2010)
- When applied to changing criminal behavior, the four-factor structure of the URICA may be more accurately represented by deletion of items 2, 8, and 24, based on findings of improved internal consistency and fit across the various scales (Polaschek et al., 2010). The internal consistency of the Contemplation scale may also be low among offenders when applied to changing criminal behaviors (alpha = .90; Polaschek et al., 2010)

Availability and Cost

The URICA is available free of charge. The URICA instruments and materials describing scoring and interpretative guidelines can be found at the following site http://habitslab.umbc.edu/urica/

Recommendations for Motivational Screening Instruments

Information regarding motivational screening instruments is based on a critical evaluation of the literature, including comparative research H[DPLQLQJ WKH HI¿FDF\ RI WKHVH L Important factors in determining the utility of motivational screens include empirical evidence supporting the reliability and validity of the instruments, cost of the instruments, and ease of administration and scoring within the criminal justice settings. Motivation can also be focused on a variety of domains (e.g., substance use, mental KHDOWK FULPLQDO MXVWLFH LQYR the area of motivational screening, instruments recommended are those that closely align with the transtheoretical model (TTM) and stages of change and that have demonstrated validity within the criminal justice system. The following instruments are recommended:

1. The Texas Christian University Motivation Form (TCU-MOTForm). This instrument is unique in identifying not only readiness to change but also variables related to motivation and treatment engagement, including problem recognition, desire for help and treatment readiness.

(or)

2. The University of Rhode Island Change Assessment Scale (URICA), which provides HI¿FLHQW LGHQWL¿FDWLRQ RI U

DQG GLUHFWO\ PDSV RQWR IRXU RXW RI WKH ¿YH transtheoretical stages of change. The 85,&$ 0 LV VSHFL¿FDOO\ GHVLJQHG IRU SHRSOH with CODs and provides simpler language and a shorter administration time.

Both of these instruments have been examined in the criminal justice system and/or among people with CODs. The URICA is recommended for settings in which it is important to determine readiness to change, while the TCU-MOTForm can also be used to assess issues related to treatment engagement. Each of these measures requires approximately 10–15 minutes to administer and score.

Assessment Instruments for Substance Use and Treatment

of correctional institutions revealed that only 19 percent of males and 23 percent of females actually received substance use treatment, and of those receiving treatment, about a third received only drug education or self-help groups (e.g., AA, NA). These findings underscore the importance of using a formal assessment approach to identify needs of offenders and to prioritize them for services, and challenges in treatment matching within an environment that often includes scarce treatment resources and with a population that has pronounced treatment needs (e.g., offenders with CODs).

Treatment Matching Approaches

Risk-Need-Responsivity Model

The Risk-Need-Responsivity (RNR) model identifies the importance of "criminogenic needs" of offenders that are related to recidivism and using this information to match offenders to different levels of treatment and supervision (Andrews & Bonta, 2010b). The "risk principle" encourages assessment of criminal risk to ensure that intensive resources (e.g., CODs treatment, substance use treatment) are reserved for offenders who are at moderate to high risk levels. Key predictors of criminal risk include "static" or unchanging factors (e.g., age, age at first arrest, number of prior arrests) and "dynamic" or changeable factors, such as criminal attitudes and beliefs, criminal peers, substance use problems, employment, education, family problems, and lack of prosocial leisure skills.

The most important predictors of criminal risk are past criminal behavior and antisocial attitudes, beliefs, and peers, although substance use problems also represents an important risk factor. Although mental illness is not an independent risk factor for recidivism, offenders who have mental disorders are at elevated criminal risk due to having high levels of criminogenic needs (e.g., ingrained criminal belief systems, poor employment history, lack of education). Offenders who have CODs are at particularly high risk for recidivism and should be a priority population for programming and specialized supervision (Drake, 2011). A range of risk assessment instruments has been developed that examines both static and dynamic risk factors and provides overall criminal risk scores and recommendations for placement in different levels of treatment and supervision. Various risk assessment instruments are described in the "Risk Assessment" section of this monograph.

The RNR model asserts that dynamic risk factors ("criminogenic needs") should be targeted in individualized assessment and offender programming to most effectively reduce recidivism. Many offender programs, including those providing treatment for CODs, do not address a range of these criminogenic needs, and as a result, are less likely to reduce recidivism (Lowenkamp & Latessa, 2005). Research indicates that there is a cumulative effect in addressing criminogenic needs, resulting in a linear relationship between the number of needs addressed in offender treatment and supervision and positive outcomes related to recidivism (Bonta & Andrews, 2010; Carey & Waller, 2011).

The RNR model also indicates the need to address "responsivity" in offender programs, referring to factors that can influence the effectiveness of interventions in evidence-based treatment (e.g., services that address dynamic risk factors/criminogenic needs). Responsivity factors include mental health problems, need for gender-specific programming, history of trauma/PTSD, need for culturally sensitive programming, and various disabilities. If unaddressed, responsivity factors can undermine engagement, retention, and outcomes in offender treatment and supervision.

Consideration of the three components of the RNR model (risk, criminogenic needs, responsivity) provides a very useful framework for matching offenders to different types and intensity of treatment and supervision. Appropriate matching based on these principles leads to reductions in

recidivism and other positive outcomes in offender programs (Andrews et al., 2006). In summary, offenders who are assessed to be at higher risk should be prioritized for intensive services, and these services should target criminogenic needs and responsivity factors in order to reduce recidivism and improve outcomes in treatment and supervision. Lower risk offenders do not require the same services or intensity of services to achieve comparable outcomes (Thanner & Taxman, 2003).

Risk-Needs-Responsivity (RNR) Simulation Tool

Crites & Taxman (2013) have developed a web-based Risk-Needs-Responsivity (RNR) Simulation Tool that categorizes community treatment programs according to their focus on evidence-based practices related to criminogenic needs and matches offenders to their particular level of risk and needs. The RNR Simulation Tool is based on the ASAM PPC model and a similar treatment matching model, Level of Care Utilization System (LOCUS), developed by the American Association of Community Psychiatrists (2009). The RNR 6LPXODWLRQ 7RRO FODVVL¿HV RIIHQGHUV SURJUDPV by assessing several domains: target, content, dosage, and implementation quality. These domains are linked to increased effectiveness of offender programs (Andrews & Dowden, 2005). Information from each domain is then used WR PDWFK RIIHQGHUV WR VSHFL¿F SURJUDPV 7KH following types of information are compiled for each domain:

- Target addresses the behavior(s) that are the focus of the particular treatment program. These include reducing the severity of substance use problems, cognitive restructuring of criminal thinking and reducing criminal peers, self-improvement and self-management strategies (e.g., improving social skills, problem solving, self-control), improving social/interpersonal skills, identifying deficits in physical/life needs (e.g., employment, education, housing), and implementing a sanctions-only approach for those who are at low risk. As noted previously, effective "targets" for offender treatment programs are those that address criminogenic needs that are linked to reducing recidivism (Andrews, 2012; Andrews & Bonta, 2010a, 2010b)
- Content addresses the therapeutic orientation of treatment programs, including the main area of treatment focus, services provided, and reinforcement of treatment skills. The content of offender programs should be a CBT skills-based approach to address factors such as antisocial behaviors, thinking, and peers, in addition to substance use disorders (Lipsey, Landenberger, & Wilson, 2007). Other key content includes social restrictiveness or supervision (e.g., curfews, probation visits, and mandatory daily program attendance), which can reduce recidivism (Drake, Aos, & Miller, 2009)
- Dosage addresses the amount (total number of hours), duration (number of weeks or months), frequency (number of times per week), and quantity (number of hours per week) of services provided by treatment programs. Dosage serves to moderate the risk for recidivism (Lipsey & Landenberger, 2005). Moreover, risk level determines the appropriate dosage necessary, with high-risk offenders generally requiring at least 300 hours of cognitive-behavioral treatment (CBT) and related services, moderate-risk offenders requiring approximately 200 hours of CBT and related services; and low-risk offenders requiring approximately 100 hours of services (Bourgon & Armstrong, 2005)
- Implementation Quality addresses whether programs are implemented as designed. Key factors include adherence to treatment protocols, proper staff training in delivering services, certification in administration of treatment protocols, supervision of staff who implement treatment protocols, use of quality assurance measures, and adequate

staff communication regarding participants' treatment progress

A second part of the RNR Simulation Tool involves profiling of offenders' risk level for recidivism. Risk level is composed of factors related to criminal history (leading to classification as "low" or "moderate/high risk" offenders), primary needs (e.g., substance use disorders, criminal thinking), clinical destabilizers (e.g., presence of mental disorders), lifestyle destabilizers (e.g., poor social supports, lack of education, unemployment, lack of stable housing), and stabilizers (i.e., opposite of destabilizing factors, such as educational achievement, stable housing, social support). Programs are categorized according to these features and placed in one of six groups (Crites & Taxman, 2013) that are differentiated by recidivism risk level, primary needs, responsivity (appropriate match between individual's needs and program services), dosage, program integrity (factors associated with implementation fidelity and successful completion), and service utilization.

Summary of Key Issues

- The Risk-Needs-Responsivity (RNR) Simulation Tool uses a series of algorithms generated from the Bureau of Justice Assistance, Survey of Inmates data set to match offenders with appropriate programs
- The tool also helps to identify gaps between offenders' needs and the existing program resources in a particular community (Crites & Taxman, 2013)
- The RNR model provides a useful framework to identify and address criminogenic needs and responsivity factors that influence treatment outcomes among offenders with CODs, including relapse and recidivism
- The RNR Simulation Tool is based on an empirically derived theoretical approach to identify the appropriate level of treatment and supervision services that are needed to promote positive outcomes among offenders who have substance use problems and CODs

Concerns

- Although the RNR Simulation Tool is based on a sound theoretical model to determine treatment matching for those involved in the justice system, it is a new approach and requires application and testing to assess its validity, including its effectiveness in reducing recidivism
- Several other assessment tools are available to examine offenders' risk and needs for psychosocial interventions. These include the Addiction Severity Index (ASI; McLellan et al., 1985), the Global Assessment of Individual Needs (Dennis, Titus, White, Unsicker, & Hodgkins, 2003), the Level of Service Inventory-Revised (Andrews & Bonta, 1995), and a range of other risk assessment instruments

Availability and Cost

Information regarding the RNR Simulation Tool is

Underlying concepts of the ASAM PPC (Mee-Lee & Shulman, 2003) include the following: (1) the biopsychosocial perspective of addiction that encompasses etiology, expression, and treatment of addiction, allowing for a more comprehensive assessment and treatment approach; (2) individualized treatment that provides a patient-driven approach; (3) multidimensional assessment (see the six domains below) that determines level of services needed; (4) treatment matching that integrates all six domains (described in the following section) and addresses issues of motivation to change, management of social/occupational risk factors, medication management H J G H W R [L ¿ F D W L R Q F U D Y L Q J P D Q D J H P H Q W D Q G other services (e.g., self-help/12-step groups, such as NA and Dual Recovery Anonymous); and (5) monitoring of care that includes relapse prevention, treatment engagement and retention, and other important social/occupational factors.

The ASAM PPC provide separate guidelines for placement in adolescent and adult treatment services. The ASAM PPC-2R guidelines operationalize six assessment dimensions that G H ¿ Q H E L R S V \ F K R V R F L D O V H Y H U L W \ Z L W K L Q W K H context of behabe7g4aa04B004800000570S /Sp00000570S /Sp0000000005510BtD 15407 >>BDC 0 -1.273

treatment and supervision that is focused primarily

- Further research is needed to examine treatment outcomes among people who are mismatched to treatment based on the ASAM PPC computerized algorithm, and to identify strategies to reduce these mismatches
- The ASAM PPC materials are somewhat costly to purchase

Availability and Cost

The most recent version of the ASAM PPC, The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions and the ASAM PPC supplement can be purchased from the American Society of Addiction Medicine at the following site: http://www.asam.org/publications/the-asam-criteria

The cost of the ASAM PPC is $95 ($85 for members of ASAM), and the supplement costs $65 and is available for the Kindle.

ASAM recommends a set of assessment and placement instruments that adhere to ASAM criteria, and these are available for purchase. Assessment and placement instruments cost between $50 and $80, and each instrument contains 25 copies. Instruments can be obtained at the following site: http://changecompanies.net/asamcriteria/assessments.php

Substance Use Assessment

employment and support status, medical status, and psychiatric status. The ASI examines the severity of problems in each of these domains over the past month and the need for treatment. The instrument also reviews indicators of emotional, physical, and sexual abuse. Although the ASI measures frequency of use, it does not address quantity of use, as quantity may be underestimated and frequency is easier to recall (McLellan et al., 1992). The ASI-5 includes interviewer severity ratings (ISR) that combine current and lifetime symptoms within each domain to help assess the need for treatment. The ASI composite summary scores (CS) are generated for each domain and assess the current severity of symptoms. (YDOXDWLRQ IDFWRUV () DUH DYDLODEOH IRU ¿YH of the domains, and clinical factors (CF) are included for all seven domains. CFs measure FXUUHQW DQG OLIHWLPH IXQFWLRQLQJ VFRUHV WKDW UHÀHFW a global severity rating. EFs measure individual functioning during the past month.

Many offender programs have developed PRGL¿HG YHUVLRQV RI WKH $6, IRU XVH LQ VXEVWDQFH use screening. A sixth edition of the ASI is now available. Revisions to the ASI-6 include

psychological functioning scales of anxiety/depression; and the TCU criminal thinking scales (CTS; Pankow et al., 2012). The ASI-6 (Pankow et al., 2012) is also significantly correlated with other validated psychological measures, such as the K10 (Kessler et al., 2003) and the PTSD Checklist (PCL; Weathers et al., 1993)

- ASI normative data is available for criminal justice populations (McLellan et al., 1992)
- The ASI is highly correlated with objective indicators of addiction severity (McLellan et al., 1980, 1985; Searles et al., 1990) and with alcohol use disorder and substance use disorder diagnoses (Rikoon, Cacciola, Carise, Alterman, & McLellan, 2006). The ASI-Drug Use section was one of three sets of screening instruments found to be the most effective in identifying substance-dependent offenders (Peters et al., 2000)
- Among people seeking substance use treatment, the ASI-6 domains/scales show good concurrent validity with other related measures and are correlated with measures of the following: (1) medical problems and physical health, as measured by the Short Form Mental Health Survey (SF-12, r score = -.64); (2) family/social support, as measured by the Social Readjustment Scale Self-Report, SAS-SR-social (r score = -.34); (3) family and social problems, as measured by the SAS-SR social (r score = .40); (4) employment, as measured by the SAS-SR Work, (r score = .76), (5) alcohol problems, as measured by the Short Index of Problems (SIP-Alcohol, r score = .68; Alterman, Cacciola, Ivey, Habing, & Lynch, 2009); (6) drug problems, as measured by the SIP-Drugs (r score = .61; Alterman et al., 2009); (7) legal problems, as measured by prior arrests (r score = .15); and (8) mental health problems,

in responses for particular domains such as employment, and items specific to alcohol use (Butler, Villapiano, & Malinow, 2009). Areas of significant differences that were found could be due to higher rates of disclosure by participants on the computerized interview as compared to

other social, occupational, and treatment areas. TCU instruments described here include both interviewer administered and self-report scales. Instruments developed for justice settings are referred to as the Criminal Justice treatment forms (TCU CJ) and contain an interviewer-administered CJ Comprehensive Intake (TCU CJ CI), and a self-report CJ Client Evaluation of Self and Treatment (TCU CJ CEST-intake). Instruments developed for community treatment settings include an interviewer-administered Brief Intake (TCU BI), a Comprehensive Intake (TCU CI), and a self-report Client Evaluation of Self and Treatment, Intake version (TCU CEST-Intake).

The self-report CEST forms for both criminal justice and community settings contain several sections, or short forms, that can be administered separately. A follow-up CEST form is also available for both community and justice settings and can be used to evaluate treatment progress over time. Other self-report instruments can be combined with both the criminal justice and community CEST forms, including the TCU Drug Screen V (TCUDS V), the TCU Criminal Thinking Scales (TCU CTS), and other mental health scales that integrate components of the K6 and K10 instruments (Kessler et al., 2003). Several TCU short forms are based on sections contained in the original interviewer-administered intake instrument. These include the global risk assessment (TCU RSKForm), the Family and Friends assessment (TCU FMFRForm), the mental health and PTSD screen (TCU TRMAForm), and physical and mental health screens (TCU HTLHForm). The TCU HTLHForm contains items from the K10 and is designed to examine psychological distress. The short forms provide a vehicle for individualized assessment to address CODs relevant to involvement in treatment.

Criminal Justice Instruments:

- The TCU CJ Comprehensive Intake (TCU CJ CI) is administered 1 to 3 weeks after program entry and queries about the past month or the past 6 months prior to incarceration. The TCU CJ CI contains sections assessing the following domains:
  - Sociodemographic background
  - Family background, including quality of relationships with family members
  - Peer relations, including quality of relationships with friends and gang affiliations
  - Criminal history, including prior arrests, involvement in illegal activities, and legal status
  - Health and psychological status, including physical and mental health (e.g., anxiety, depression), and history of hospitalization
  - Drug history, including frequency of alcohol and drug use over the past month and past 6 months and prior treatment history. Alcohol use is assessed in more detail, including quantity and patterns of drinking over the past month. Problems caused by drug and alcohol use are based on DSM-IV criteria
  - AIDS risk assessment, including risky behaviors

  The TCU CJ CI requires approximately 90 minutes to administer. Instructions are provided to the interviewer to read aloud to the participant explaining the purpose of the assessment, in addition to answer cards to help guide the format of participants' responses. "Skip logic" items are provided that can reduce the duration of administration.

- The TCU CJ Client Evaluation of Self and Treatment (TCU CJ CEST; Joe, Broome, Rowan-Szal, & Simpson, 2002; Knight, Simpson, & Morey, 2002) is a self-report instrument for use with offenders. The instrument examines treatment motivation and a range of other psychosocial factors affecting treatment. The TCU CJ CEST reviews the following domains:
  - Treatment motivation, with subscales of problem recognition (PR), desire for

also included in the social functioning domain and examines social values. The follow-up CEST-Intake is identical to the CJ CEST version in coverage of domains and analysis of treatment engagement, retention, and progress. A manual is provided to assist in scoring and interpretation of the CEST-Intake.

Positive Features

- The TCU intake and assessment instruments have been used in a wide variety of offender settings (Farabee, Prendergast, & Cartier, 2002; Czuchry & Dansereau, 2000; Joe, Rowan-Szal, Greener, Simpson, & Vance, 2010; Pankow & Knight, 2012)
- The TCU CJ CEST and community CEST instruments include norms for both offender and community treatment populations
- The TCU intake and assessment instruments provide two sets of forms that are tailored for offender and community treatment settings
- Each of the TCU intake and assessment instruments is fully structured and addresses multiple domains, including diagnostic criteria for various disorders. The instruments can be administered by nonclinicians and include a straightforward set of items/questions
- The self-report CEST forms can be administered as short, one-page assessments or can be combined to provide a more comprehensive assessment, thus allowing programs flexibility to tailor their approach to the needs of participants and to the needs of the program. For example, several short forms are available to assess mental health, social functioning and other related domains, and these can be administered individually or in combination with CEST forms
- The assessment forms examine DSM criteria for drug and alcohol use disorders. The self-report TCU CJ CEST can be combined with other forms, such as the TCU CTS, to assess risk for recidivism and to provide a more comprehensive assessment. Criminal thinking as measured by the TCU CTS is correlated with lower treatment motivation/engagement and poorer psychological and social functioning (Garner et al., 2007)
- TCU CJ CEST motivation scales are correlated with treatment engagement among offenders (Pankow et al., 2012; Simpson et al., 2012)
- The TCU CJ CEST domains of psychological functioning, social functioning, and motivation are related to relevant domains on the Addiction Severity Index, supporting the convergent validity of the CEST instrument. For example, treatment motivation and psychological and social functioning are correlated with ASI measures of legal status, drug problems, and psychiatric problems (Pankow et al., 2012)
- Among female offenders, the TCU TRMAForm and TCU HLTHForm are highly correlated with the psychological functioning scales/domains of anxiety and depression in addition to social functioning scales/domains of hostility and risk taking, supporting the concurrent validity of these measures (Rowan-Szal et al., 2012)
- The TCU CJ CEST shows acceptable internal consistency in justice settings across domains of treatment motivation (alphas range .60–.80), psychological functioning (alphas range .71–.74), and social functioning (alphas range .71–.80; Garner et al., 2007). Other studies provide support for the internal consistency of the entire CEST instrument (Simpson, 2004; Simpson, Knight, Dansereau, 2004) and for the specific domains that can be used as independent assessment instruments (e.g., TCU psychological functioning and TCU social functioning domains; Rowan-Szal et al., 2012; Simpson et al., 2012)
- TCU CJ CEST subscales of social functioning and psychological functioning represent unitary dimensions, as indicated

by confirmatory factor analyses (Garner et al., 2007; Simpson et al., 2012)

- The CJ CEST domains have good test-retest reliability across subscales (Garner et al., 2007)
- The TCU CEST Community Treatment forms demonstrate good internal consistency for domains of treatment motivation (alphas range .88–.90), social functioning (.71–.90), and psychological functioning (.80–.91; Joe et al., 2002; Simpson, 2004)
- The TCU TRMAForm, TCU HLTHForm, and their subscales show good internal consistency among female offenders (alphas range .75–.94; Rowan-Szal et al., 2012)

Concerns

- Further study is needed to determine the validity and reliability of both the TCU intake and assessment forms in detecting the severity and scope of substance use disorders, mental disorders, and related psychosocial problems
- Many of the existing studies of the TCU intake and assessment forms in justice settings have been conducted by the developers of the instruments. Studies conducted by other research teams are needed to confirm these results
- The criminal justice and community treatment intake and assessment forms do not include a module to detect psychosis
- The TCU CEST does not address antisocial behaviors
- The domain of treatment motivation and its subscales appear to have relatively low internal consistency, particularly the subscales related to desire for help (alpha = .67) and treatment needs (alpha = .60). Results of confirmatory factors analyses indicate that the four treatment motivation subscales may lack structural integrity and may not represent unitary dimensions (Garner et al., 2007)

Availability and Cost

Each of the TCU intake and assessment instruments is available at no cost. The community treatment forms, including scoring interpretation and norms can be found at the following site: http://ibr.tcu.edu/forms/tcu-core-forms/

use, variables calculated include the number of days of use, the longest period of use, and the longest period of abstinence; however, this varies across drug class. For example, the quantity of marijuana use can be more accurately assessed in terms of frequency (number of joints; Robinson, Sobell, Sobell, & Leo, 2012). The TLFB approach provides a more accurate and comprehensive assessment of individual drinking and drug use patterns compared with typical quantity and frequency measures that may underestimate substance use behavior (Sobell et al., 2003). The TLFB protocol requires approximately 10–30 minutes to complete and is available in several languages.

Positive Features

- The TLFB measure can be administered via interview or computer. The computerized version provides detailed instructions for self-administration and allows measurement of time intervals up to 12 months. The computerized version of the TLFB requires the same amount of time to administer as the interview version
- The TLFB has been used successfully with justice populations (Broner, Mayrl, & Landsberg, 2005; Easton et al., 2007), including DUI/DWI offenders (Brown et al., 2008; Fridell, Hesse, & Billsten, 2007; Palmer, Ball, Rounsaville & O'Malley, 2007)
- In a meta-analysis of drug-involved

have also been found between the TLFB and DUF on use versus non-use across all drug classes (r scores range .97–1.00; O'Farrell et al., 2003)

v

forms address key criminogenic needs and psychosocial factors related to treatment intake and matching, and can be tailored DFFRUGLQJ WR WKH VSHFL¿F UHVRXUFHV DQG assessment needs of a particular justice

True Response Inconsistency (TRIN-r); the Lie scale, which is now Uncommon Virtues (L-r); and the K-Scale (Correction Scale), now referred to as Adjustment Validity (K-r). The latter two

- The MMPI-2 is well validated in a variety of settings and has good psychometric properties (Butcher, Graham, Ben-Porath, Tellegen, & Dahlstrom, 2001; Graham, 2000; Greene, 2000)
- A derived MMPI-RF measure of psychopathy corresponds well with other validated measures (e.g., Psychopathic Personality Inventory; Lilienfeld & Andrews, 1996) and traits (antisocial behaviors, narcissism; Phillips, Sellbom, Ben-Porath, & Patrick, 2014; Sellbom, Ben-Porath, Lilienfeld, Patrick & Graham, 2005; Sellbom et al., 2012)
- The MMPI-2 RC scales demonstrate concurrent validity with other similar substantive measures (Tellegen, Ben-Porath, & Sellbom, 2009). For example, RC2-low positive emotion is correlated with depressive mood symptoms (Arbisi, Sellbom, & Ben-Porath, 2008; Forbey & Ben-Porath, 2007; Handel & Archer, 2008) and social anxiety (Forbey & Ben-Porath, 2008), and RC1-somatic symptoms are correlated with somatoform problems (Arbisi et al., 2008; Forbey & Ben-Porath, 2007, 2008)
- The MMPI-2 RC scales indicate high internal consistency across gender groups in clinical representative samples (alphas range .78–.95; Rogers, Sewell, Harrison, & Jordan, 2006). The RC scales show improvement over the clinical scale in reducing interscale correlations (Rogers, Gillard, Berry, & Granacher, 2011; Tellegen et al., 2003)
- Several studies support the validity of the revised or added RF validity scales for the MMPI-2RF. The VRIN-r, TRIN-r, L-r, and K-r are useful in identifying underreporting among both clinical and nonclinical samples (Sellbom & Bagby, 2008). The Fp-R indicates incremental utility in detecting overreporting of psychopathology (Tellegen & Ben-Porath, 2008. The Fs scale also provides incremental utility in identifying exaggerated or "faked" somatic complaints (Wygant et al., 2007). The FBS-r, F-r, and F-s are able to identify neurocognitive, emotional, and somatic complaints (Wygant et al., 2010). Among offenders, the F-r and Fp-r were able to identify malingering of psychopathology (Sellbom, Toomey, Wygant, Kurcharski, & Duncan, 2010; Wygant et al., 2011), and these scales have been shown to be effective when compared to the Structured Interview of Reported Symptoms (SIRS; Rogers, Bagby, & Dickens, 1992)
- The Response Bias Scale (RBS; Gervais et al., 2007) is able to identify the validity of reported symptoms in forensic settings as demonstrated by its discriminatory ability to distinguish between those who pass or fail the symptom validity tests (Word Memory Test: Green, 2003; Test of Memory Malingering: Tombaugh, 1996). The RBS scale is also associated with other symptom validity scales such as the F-r, Fp-r, and Fs. Combinations of these scales can improve the specificity of overreported psychopathology and somatic complaints (Wygant et al., 2010)

Concerns

- The MMPI-2 requires somewhat more time to administer than the PAI
- The MMPI-2 RF does not include updated norms and is based on norms from the MMPI-2. Many validation studies of the MMPI-2RF employ the original validation data for the MMPI-2, and few studies have been conducted by those other than the instrument developers
- The MMPI-2 RC scales provide poor convergent validity for related areas of psychopathology (Rogers et al., 2011)
- Clinical elevations on the RC scales are difficult to interpret when used in combination, as scales can provide contradictory information. For example, RC1 demonstrates clinical elevations in over 60 percent of cases (somatic complaints), but these profiles were classified as within normal limits. The RCd, which reflects general psychiatric

distress, shows no elevation for those who endorsed persecutory ideation on RC6 (Rogers et al., 2011)

- Although the RBS scale improves identification of symptom validity, other symptom validity tests are still recommended during the assessment process (Heilbronner et al., 2009)
- The FBS-r and Fs may not perform well in detecting malingering, as they are focused more on somatic and cognitive deficit complaints (Sellbom et al., 2010)
- Many of the studies that validate scales of the MMPI-2 RF use archival data sets that have previously been used in validating the MMPI-2 and thus employ convenience sampling rather than replication in diverse samples
- Since the MMPI-2 is based on psychological constructs developed in the 1940s, both the content and clinical scales are somewhat heterogeneous. As such, there is some overlap among scales, which lessens the discriminant validity of this measure. For example, while it is possible to differentiate between bipolar disorder and schizophrenia using the Depression (Dep) content scale, no clinical or content scales on the MMPI-2 are able to differentiate between bipolar depression and unipolar depression (Bagby et al., 2005)

Facet Scales for each MCMI-III Personality Scale. The Facet Scales were developed using factor analytic techniques and are included to guide clinicians in the interpretation of the Clinical Personality Patterns and the Severe Personality Pathology Scales. The scales aid in identifying VSHFL¿F SHUVRQDOLW\ SURFHVVHV H J VHOI LPDJH interpersonal conduct, cognitive style) that contribute to overall scale elevations. Base rates RI GLVRUGHUV LQ WKH VSHFL¿F SRSXODWLRQ DUH XVHG

Concerns

style, treatment complications, and subject's environment.

The PAI instrument includes 344 items and 22 nonoverlapping full scales, with 4 validity scales, 11 clinical scales, 4 treatment consideration scales, and 2 interpersonal scales. Validity scales include inconsistent responding (ICN), infrequency of endorsed response (INF), negative impression management (NIM), and positive impression management (PIM). Clinical scales include separate measures for alcohol problems (ALC), drug problems (DRG), somatic complaints (SOM), anxiety (ANX), anxiety-related disorders (ARD), depression (DEP), mania (MAN), paranoia (PAR), schizophrenia (SCZ), borderline personality disorder (BOR), and antisocial personality disorder (ANT). Treatment consideration scales include aggression (AGG), suicide ideation (SUI), stress (STR), nonsupport or lack of social support (NON), and treatment rejection (RxR). Interpersonal scales include dominance (DOM) DQG ZDUPWK :50 $ 7 VFRUH • RQ WKH clinical scales, treatment scales, and interpersonal VFDOHV LQGLFDWHV FOLQLFDOO\ VLJQL¿FDQW SUREOHPV There are 27 critical items that indicate acute problems (e.g., suicidal ideation) for which follow-up with the client should be provided. The PAI requires approximately 50 minutes to complete (Morey, 2007).

Positive Features AIPInterperson -1uAs< the J26dB6 k /GS0 gs /TT0 1 Tf 0 -2.091 T25subject's C /SpL wln[7a

example, people seeking treatment may have higher NIM scale scores as they may exaggerate symptoms to secure treatment. PIM scores may also be elevated in justice settings as a result of attempts to deny potential problems, such as substance use (Douglas et al., 2007; Morey & Quigley, 2002; Newberry & Shuker, 2012). INF and ICN scores may also be inflated among offenders, who tend to respond inconsistently and to endorse items with low base rates (Douglas et al., 2007; Newberry & Shuker, 2012). However, scale scores may be affected by poor reading abilities (Nikolova, Hendry, Douglas, Edens, & Lilienfeld, 2012)

- Inappropriate use of cut-off scores with offenders may lead to misclassification in determining "risk" level and in assignment to services (Edens, Poythress, & Watkins-Clay, 2007)
- For offenders with high PIM scale scores 7 VFRUHV • WKH YLROHQFH6RWHQWLDO index (composed of items from different PAI scales, including drug use, aggression, and antisocial behaviors) and the SUI and STR scales may not be useful in assessing risk, and ANT scale scores may not as effectively predict problem behaviors (Walters, 2007)
- The PAI's alcohol and drug scales are susceptible to denial since the item content is not subtle

Availability and Cost

The PAI is available at cost from Psychological Assessment Resources at the following site: http://www4.parinc.com/Search.aspx?q=PAI

There are numerous PAI resources available, including the instrument, scoring sheets, an interpretive guide, a user manual, and scoring software that generates interpretive reports. Supplementary software is also available that generates interpretive reports geared for correctional settings.

A PAI kit can be purchased for $315 and includes the professional manual, answer booklets, the instrument, and materials for hand scoring (e.g., SUR¿OH IRUPV

Recommendations for Assessment of Mental Disorders

Information describing assessment instruments for mental disorders is based on a critical HYDOXDWLRQ RI WKH UHVHDUFK H[D of these instruments. Important indicators used in evaluating instruments include the following: empirical evidence supporting both the reliability and validity of the instrument, ability to assess multiple mental health problems/disorders, the relative cost of the instrument, ease of administration and interpretation, and previous use within justice settings. Although the assessment instruments provide information that addresses the range of mental disorders described in the DSM-IV, it is highly desirable for these instruments to be closely aligned with the newly implemented DSM-5 criteria to allow for a seamless transition from WKH '60 ,9 WR '60 GLDJQRVWLF FO systems. Based on these considerations, the following instrument is recommended for use in assessing mental disorders for people with co-occurring disorders in the justice system:

- The Personality Assessment Inventory (PAI)

The PAI assesses personality traits, mental health problems/disorders, and other treatment-related problems and requires approximately 45–60 minutes to administer and 25–30 minutes to score and interpret. The PAI provides several validity indices and facilitates clinician follow-up to individual item responses. The PAI should be administered and interpreted by a trained and OLFHQVHG FHUWL¿HG PHQWDO KHD

Assessment and Diagnostic Instruments for Co-occurring Mental and Substance Use Disorders

This section reviews instruments that are used to diagnose or assess CODs. Included are assessment instruments that examine other biopsychosocial domains related to CODs. Diagnostic instruments include those that evaluate DSM or ICD disorders and provide a diagnosis for a range of mental and substance use disorders. Some instruments, such as the GAIN and MINI, which include multiple versions (e.g., screening, assessment) are described in this and other sections. In contrast to instruments described in screening sections, assessment instruments described in this section require more time to administer; provide more detailed and comprehensive coverage of issues related to the various disorders; and are designed to yield formal diagnoses and treatment plan recommendations, including levels and types of services that are needed. The assessment and diagnostic instruments described below require V L J Q L ¿ F D Q W W U D L Q L Q J L Q D G P L Q L V W U D W L R Q V F R U L Q J and interpretation. As a result, these instruments should be administered by trained clinicians who D U H O L F H Q V H G F H U W L ¿ H G R U R W K H U Z L V H F U H G H Q W L D O H G L Q assessing and diagnosing mental and substance use disorders and related psychosocial problems.

Assessment Instruments for Co-occurring Mental and Substance Use Disorders

Alcohol Use Disorders and Associated Disabilities Interview (AUDADIS-IV)

The AUDADIS-IV (Grant & Dawson, 2000) is both an assessment and diagnostic instrument, and is a fully structured clinical interview that is based on the DSM-IV and ICD-10 criteria. The AUDADIS-IV assesses alcohol, drug, and nicotine use disorders. It also assesses mental disorders, including mood disorders, anxiety disorders, and DSM-IV personality disorders, in addition to the family history of mental disorders. The instrument is standardized to diminish the unreliability that is often found in other structured interviews and navigates complex diagnostic criteria by use of multiple short questions. If the respondent meets criteria for a particular diagnosis, all questions in the module are asked to provide a more complete dimensional assessment of related problems. The instrument requires approximately 1 hour to administer and provides both lifetime (prior to past 12 months) and current diagnoses (past 12 months). The AUDADIS-IV examines the onset of disorders; duration of symptoms of each disorder; the presence of co-occurring disorders; severity and impairment of symptoms, including "rule out" causes of symptoms (e.g., use of medication or drugs); frequency of substance use, patterns of use; and quantity of use. The most recent version of the AUDADIS-IV includes additional risk factor scales related to social and occupational functioning, such as the self-reported discrimination scales (e.g., reported bias against race, weight, ethnicity, culture). The instrument also examines stressful life events and perceived stress.

Positive Features

- The AUDADIS-IV is fully structured and translates DSM-IV criteria into simpler language and thus can be administered by nonclinicians
- The AUDADIS-IV has been translated into Spanish
- The AUDADIS-IV was designed to comprehensively assess for CODs among people who have substance use disorders
- The AUDADIS-IV provides adequate coverage of quantity, frequency, and duration of substance use disorders

income,) in a large national epidemiological survey (Gelhorn, Sakai, Kato Price, & Crowley, 2007; Hoertel, Le Strat, Schuster, & Limosin, 2012; Vaughn et al., 2011; Vaughn et al., 2010)

DFFRUGLQJ WR WKH GH¿QLWLRQV DQG FULWHULD RI WKH ,QWHUQDWLRQDO &ODVVL¿FDWLRQ RI Diseases, 10th Revision (ICD-10) and the DSM (DSM-IV). The CIDI is one of the most widely used structured diagnostic interviews internationally, as it was GHYHORSHG VSHFL¿FDOO\ IRU XVH DPRQJ GLIIHUHQW cultures and settings. The instrument was derived from the Diagnostic Interview Schedule (DIS; Robins, Helzer, Croughan, & Ratcliff, 1981) and accommodates diagnoses based on WKH GH¿QLWLRQV DQG FULWHULD RI ERWK WKH ,&' DQG '60 7KH &,', ZDV ¿UVW XVHG LQ DQG was revised and expanded in 1998 by the WHO World Mental Health (WMH) initiative to address subthreshold impairment, symptom severity and persistence, risk factors, internal and external (global) impairment, consequences, patterns of treatment, and treatment adequacy, in addition to diagnosis of mental disorders (Kessler & Üstün, 2004). The WMH-CIDI contains 22 diagnostic sections, including anxiety, mood, eating, tobacco, DQG VXEVWDQFH XVH GLVRUGHUV DWWHQWLRQ GH¿FLW hyperactivity disorder (ADHD), conduct disorder, psychosis, and personality disorders. There are four sections assessing functioning and physical comorbidity, two sections assessing treatment, seven sections assessing sociodemographics, and two sections assessing methodological factors (e.g., interviewer observations). The CIDI-SAM (Substance Abuse Module) can be used separately, if desired, to diagnose substance use disorders.

Positive Features

- Administration of the CIDI does not require use of mental health professionals or significant clinical training to administer
- The CIDI provides both ICD-10 and DSM-IV diagnoses
- A diverse sample was used to develop the instrument, including individuals with a broad range of alcohol and drug use severity
- The WMH-CIDI has been translated into several languages using the standard WHO translation and back-translation protocol
- A computerized version of the CIDI is available, which contains a scoring algorithm to provide a diagnosis. The computerized version has the ability to handle more elaborate "skip" patterns, while covering the same information as the paper and pencil version (WHO, 2004)
- The CIDI has been used to diagnose disorders among people with intoxicated driving charges (Lapham, Baca, McMillan, & Lapidus, 2006; Shaffer et al., 2007), prisoners (Brinded, Simpson, Laidlaw, Fairley, & Malcolm, 2001), and juvenile offenders (Steinberg, Blatt-Eisengart, & Cauffman, 2006)
- The CIDI-SAM shows acceptable agreement with the Schedules for Clinical Assessment in Neuropsychiatry (SCAN; Wing et al., 1990) in diagnosing alcohol use disorders (kappa = .69) and cocaine use disorders (.61; Compton, Cottler, Dorsey, Spitznagel, & Mager, 1996). A nationally representative U.S. survey also indicates positive findings for the AUC for the WMH-CIDI for substance use disorders (AUC = .72–.99), anxiety disorders (AUC = .74–93), mood disorders (AUC = .87–.97), and "any" disorder (AUC = .76; Haro et al., 2006). According to this same survey, the CIDI-SAM demonstrates good test-retest reliability for substance use disorders over a 1-week period (kappas range 63–.80; Horton, Compton, & Cottler, 2000)
- The CIDI has good sensitivity (74 percent) and specificity (98 percent) for any substance use diagnosis (Haro et al., 2006) and has adequate sensitivity for anxiety disorders (84 percent), mood disorders (69 percent), or "any" disorder (78 percent). The CIDI has excellent specificity (93 percent, 97 percent, and 91 percent for each of these respective disorders; Haro et al., 2006), and good positive predictive values and negative predictive values
- The WMH-CIDI demonstrates good sensitivity, specificity, positive predictive values, and negative predictive values

cannot be administered and contains less detailed information examining service utilization and treatment history. The GAIN-I core requires 60–75 minutes to administer. The GAIN-M90 monitors treatment progress and is administered at 6, 9, and 12 months following treatment initiation; it requires approximately 60 minutes to administer.

Positive Features

- The GAIN-Q and GAIN-I is designed for use in justice settings, primary care settings, substance use treatment programs, and other social service programs
- Norms for the GAIN have been developed for adults and adolescents and for different levels of care. Additional norms are being developed by gender, race/ethnicity, CODs, and for juvenile and adult offenders
- Scoring software is available to interpret scores for purposes of diagnosis and treatment planning. Personal feedback reports (PFR) are also available
- Computerized versions of the GAIN are available that provide interpretation of assessment and validity reports to identify erroneous or missing data. A wide variety of support services are available through the GAIN Coordinating Center

between co-occurring psychopathology (kappas range .65–1.00; Shane, Jasiukaitis & Green, 2003)

- Among adolescents, the GAIN-I has good internal consistency for three subscales of internal mental distress, behavior complexity, and crime/violence (Dennis et al., 2006; Titus et al, 2008). Original scales were highly correlated with shortened subscales among both adults and adolescents (Titus et al., 2008)

Concerns

- Training is strongly recommended before administering the GAIN. or vÌÚê¬Ñ„

Information describing the GAIN-I administration, scoring, and norms can be found at the following site: http://www.gaincc.org/products-services/instruments-reports/gaini/

Diagnostic Instruments for Co-occurring Mental Health and Substance Use Disorders

Diagnostic Interview Schedule–Fourth Edition (DIS-IV)

The DIS-IV is a fully structured diagnostic interview instrument designed for research purposes (Blouin, Perez, & Blouin, 1988; Robins et al., 1981) and has been updated to coincide with revisions to diagnostic categories in the DSM. Revised versions of the DIS have improved accuracy in identifying a range of mental disorders. A self-administered computerized version of the DIS is available (C-DIS), although staff must be present to address respondents' questions. Administration of the DIS does not require clinical experience. The DIS-IV has 19 diagnostic modules covering over 30 Axis I disorders, which include demographic and risk factors, sequencing of comorbid disorders, observations of psychotic symptoms or other problems during the interview, and a range of individual modules examining different types of disorders related to mood, anxiety, eating, schizophrenia spectrum, somatization, substance use disorders, antisocial personality disorder, ADHD, dementia, and gambling. The DIS provides information regarding both current and lifetime diagnoses of common mental disorders.

Positive Features

- The DIS can be administered by nonclinicians, requires minimal training, and has been translated into many languages
- The DIS has been used to diagnose mental disorders among offenders (Lo & Stephens, 2000; Teplin et al.,1996; Wiesner, Kim, & Capaldi, 2005) and people with substance use disorders (Havassy, Alvidrez, & Owen, 2004; Horton, Compton, & Cottler, 1998)
- In addition to detecting the presence of mental disorders in the justice system, the DIS has been used to refer offenders to treatment (Lo, 2004; Teplin, 1990)
- The DIS includes an antisocial personality disorder (ASPD) module. DIS-IV diagnoses of ASPD are correlated with substance use and chronic patterns of offending (Wiesner et al., 2005)
- The DIS has good agreement with the MAST (.79) in detecting alcohol disorders among individuals treated for mental disorders (Goethe & Fisher, 1995). Reliability of DIS diagnoses is quite good because interview questions, probes, and coding procedures are carefully described (Compton & Cottler, 2004)
- The DIS has adequate agreement with the SCAN for diagnosis of substance use disorders and for depression (Compton & Cottler, 2004) and has excellent specificity (90 percent) in detecting depression (Eaton Neufeld, Chen, & Cai, 2000)
- The DIS demonstrates adequate agreement with medical chart diagnoses (Robins, Helzer, Ratcliff, & Seyfried, 1982)
- The DIS diagnoses provide adequate agreement with most lifetime disorders, as determined by the DSM-III-R among Så ä´ Â ø º àÂ í’ ð Ð v à `

diagnosing men who are incarcerated in jail (Abram & Teplin, 1991)

Concerns

- The DIS is quite lengthy, requiring 90–120 minutes to administer. However, it is possible to omit sections of the DIS that are not of interest
- Further validation of DIS diagnoses is needed with offenders
- Structured instruments such as the DIS may fail to detect 25 percent of those abusing alcohol (Drake et al., 1990) and possibly a higher proportion who are abusing illicit substances (Stone, Greenstein, Gamble, & McLellan, 1993)
- There is poor agreement between the DIS and the Schedule for Affective Disorders and Schizophrenia- Lifetime (SADS-L) in diagnosing depression among individuals who have CODs (Hasin & Grant, 1987)
- The DIS may be overly sensitive in diagnosing major depressive disorder (Helzer et al., 1985)
- The DIS has low agreement with the SCAN for diagnosis of depression (Eaton et al., 2000)
- The DIS may not accurately diagnose anxiety disorders (e.g., panic, social phobia) or schizophrenia (Anthony et al., 1985; Cooney, Kadden, & Litt, 1990; Erdman et al., 1987; Summerfeldt & Antony, 2002)
- Caution is urged when using the DIS as a primary diagnostic tool, as agreement between the DIS and clinician diagnosis has sometimes been poor in comparison to that of the SCID (Blanchard & Brown, 1998)
- The C-DIS provides poor to moderately good (-.05–.70) test-retest reliability in diagnosing CODs, depending on the type of mental disorder (Ross, Swinson, Doumani, & Larkin, 1995)
- The DIS is not sensitive to response styles and does not provide methods for detecting dissimulation (Alterman et al., 1996)

Availability and Cost

A copy and license for the use of the DIS (computerized version) may be purchased at the following site: http://epidemiology.phhp.ufl.edu/assessments/c-dis-iv/brochure

The cost for licensing ranges from $1,000 to $2,000.

The Mini International Neuropsychiatric Interview (MINI)

The MINI (Sheehan et al., 1998) is a 120-question structured diagnostic interview used to evaluate DSM and ICD Axis I mental disorders (although the DSM-5 does not have axes, some of these frameworks are built around DSM-IV and earlier versions), including substance use disorders. The instrument was designed as a brief diagnostic screen and has been used in numerous research and clinical settings. The MINI provides a family of structured interviews, which includes the MINI,

Positive Features

- Only brief training is required to use the instrument
- The MINI provides a diagnostic impression for major "Axis I disorders" and examines a broad range of symptoms. The instrument requires approximately 20 minutes to administer to individuals who do not have a mental disorder
- The MINI has been translated into many languages and includes norms for several subpopulations (Sheehan et al., 1998)
- The MINI-Plus has been used with offenders to assess current and lifetime mental and substance use disorders (Black et al., 2007; Cuomo, Sarchiapone, Di Giannantonio, Mancini, & Roy, 2008; Gunter et al., 2008), including antisocial personality disorder (Black, Gunter, Loveless, Allen, & Sieleni, 2010). In a study of the MINI-Plus with a prison sample (Black et al., 2004), the measure was easily administered by correctional staff, well received by prisoners, and it accurately assessed mental disorders in this population
- The MINI clinician-administered interview demonstrates good sensitivity (62–96 percent) and specificity (86–100 percent) across almost all current/lifetime Axis I disorders as determined by the SCID-I patient clinical interview (Sheehan et al., 1998). Similarly, the MINI patient rated self-report instrument has adequate sensitivity (60–89 percent) and good specificity (74–99 percent) for many of the current/lifetime Axis-I diagnoses. The MINI also has good sensitivity (67–89 percent) and specificity (72–97 percent) for many CIDI (Composite International Diagnostic Interview) DSM-III-R disorders. Overall specificity is good for the MINI as compared to other structured clinical interviews (Sheehan et al, 1998)
- Agreement between MINI clinician-rated and CIDI diagnoses for psychotic disorders is adequate (kappas range .68–.82), as are those between the MINI and SCID–I diagnoses (Sheehan et al., 1998)
- Interrater reliability estimates for the clinician-administered version of the MINI ranges .79–1.00 for all subscales. Fourteen of the 23 test-retest reliability values are greater than .75 (range = .35–1.00, and only one is below .50; Sheehan et al., 1998)
- The MINI shows good concordance with SCID DSM-IV diagnoses (kappas range .90–1.0; Sheehan et al., 1998)
- The MINI-Kid shows good sensitivity (71–100 percent) and specificity (74–99 percent) in identifying mental disorders as determined by the K-SADS-PL (Schedule for Affective Disorders and Schizophrenia for School-Aged Children; Kaufman et al., 1997). For individual diagnosis, sensitivity is adequate (67–100 percent) and specificity (73–99 percent) is good across most disorders (Sheehan et al., 2010). Interrater reliability for the MINI-Kid is also good (Sheehan et al., 2010)
- Test-retest reliability for the MINI-Kid is good for any disorder and .75–1.00 for individual disorders over 1–5 days (Sheehan et al., 2010)

Concerns

- Further validation is needed of the MINI-Screen with offender populations
- The MINI does not consider symptom severity, and thus may generate unnecessary referrals for treatment. The MINI does not assess cognitive impairment
- The MINI-Plus requires an average of 41 minutes to administer to offenders, which may inhibit broad use of the instrument with this population (Black et al., 2004)
- Although malingering, denial of symptoms, and other response sets are common problems in justice settings, the MINI is not able to detect the presence of these response sets
- The psychosis and major depression modules of the MINI-Plus can be

somewhat difficult and confusing to administer (Black et al., 2004)

- The MINI-Plus clinician-administered interview exhibits lower sensitivity for substance use disorder and dysthmia (42–52 percent), as determined by the SCID-I patient version. Further, MINI patient rated self-report diagnoses for many anxiety disorders, bulimia, and current/lifetime mania have low sensitivity (17–55 percent). Low sensitivity for the MINI clinician-administered interview 18713 >>BD22 >>BDC T* [(mani7 0 -1.e22bxr5LoraphobD (dsimple phobD (diso
de(kappa current/lifetime

The PRISM-CV-IV is available for purchase and includes all software required for administration, scoring, and interpretation. PRISM administration does not require the software, but it is recommended that a license be purchased from Blaise ® Licensing. Information including cost (approximately $200) can be obtained by requesting a software quote through the following site: https://www.westat.com/our-work/information-systems/blaise percentC2 percentAE-distribution-training/blaise-licensing-ordering

The PRISM-CV-IV software package includes WKH LQWHUYLHZ SURWRFRO DQG FRGHERRN WKDW GHOLQHDWHV interview questions and diagnostic variables, a manual that provides diagnostic information for scoring and interpretation of interviews, a user guide, and information on how to export data to other statistical software programs. The cost of this package is $1,800.

7UDLQLQJ DQG FHUWLILFDWLRQ IRU DGPLQLVWUDWLRQ RI WKH PRISM-CV-IV is available. The cost of training ZRUNVKRSV LV DQG FHUWLILFDWLRQ FRVWV DUH $200.

Paper instruments including the training manual for scoring and interpretation are available upon request by sending email correspondence to the following address: AivadyaC@nyspi.columbia.edu

Psychiatric Diagnostic Screening Questionnaire (PDSQ)

The PDSQ (Zimmerman & Mattia 2001b) is a 126-item self-administered instrument that assesses 13 of the most common DSM-IV mental disorders in outpatient mental health settings. The instrument was designed to assess current and recent symptomatology and to provide background information prior to providing a more extensive diagnostic evaluation. The PDSQ H[DPLQHV ¿YH DUHDV LQFOXGLQJ GLDJQRVWLF mood disorders, anxiety disorders, substance use disorders, and somatoform disorders. The PDSQ also includes a six-item screen for psychosis. The instrument has undergone several iterations to enhance the reliability and validity, and indices of mania, dysthymic disorder, and anorexia were eliminated from the instrument due to poor psychometric features. At recommended cut-off scores, the PDSQ has sensitivity of greater than 90 percent for major depressive disorder, obsessive-compulsive disorder, PTSD, generalized anxiety disorder (GAD), panic/agoraphobia/social phobia, alcohol use disorders, and bulimia or somatoform disorders (Zimmerman, 2002; Zimmerman & Mattia, 2001a).

Positive Features

- The PDSQ requires only 15 minutes to administer, yet reviews a range of mental disorders
- The PDSQ was developed to be aligned with DSM diagnostic classifications
- The PDSQ has been used extensively with populations that have CODs and may assist in detecting disorders that are missed during unstructured clinical evaluations
- Cut-off scores were chosen to optimize sensitivity (> 90 percent; Zimmerman & Mattia, 2001a)
- The PDSQ has been used to diagnose mental disorders in justice settings (Stuart, Moore, Gordon, Ramsey, & Kahler, 2006; Swogger, Walsh, Houston, Cashman-Brown, & Connor, 2010; Weitzel, Nochajski, Coffey, & Farrell, 2007) and among people with substance use disorders (Simmons, Lehmann, & Cobb, 2008; Weitzel et al., 2007)
- PDSQ subscales related to depression are correlated with victimization of women and PTSD among women who are arrested for domestic violence (Stuart et al., 2006)
- Among offenders, the PDSQ subscales of GAD and PTSD are correlated with impulsive aggression (Swogger et al., 2010) DWLQJ GLVRUGHUV
- The PDSQ results in a 42 percent rate of referral for further mental health evaluation among drug offenders, a rate similar to those referred for evaluation in other

substance-involved populations (Harris & Edlund, 2005; Watkins et al., 2004; Weitzel et al., 2007)

- The PDSQ has a low false positive rate in identifying Axis I disorders (30 percent; Zimmerman & Chelminski, 2006). Among psychiatric outpatients, the AUC for the PDSQ is good for those with and without diagnosed substance use disorders (.83 and .86 respectively) as determined by the SCID-I, across a range of disorders (Zimmerman, 2008; Zimmerman, Sheeran, Chelminski, & Young, 2004)
- Among psychiatric outpatients with substance use disorders, the PDSQ has good sensitivity (92 percent) and adequate specificity (63 percent) in identifying co-occurring mental disorders (Zimmerman, 2008; Zimmerman & Chelminski, 2006; Zimmerman et al., 2004)
- The PDSQ has good to excellent internal consistency (alphas • for total and .83 for most subscales); test-retest reliability over two weeks (r = .92 for total • for individual subscales mean r score = .83); and discriminant, convergent, and concurrent validity (Zimmerman & Mattia, 2001a)

Concerns

a description of lifetime symptoms and dedicates very little time to current symptoms. The 45-item SADS-C examines current symptoms and changes in these symptoms. The global assessment scale of the SADS-I describes symptoms experienced over particular intervals of time following the initial SADS-L interview.

Positive Features

- The SADS has been found to be more effective than the DIS in diagnosing depressive disorders (Hasin & Grant, 1987)
- Interrater reliability is excellent for current disorders and is good for past disorders
- The SADS has been translated into several languages
- The instrument examines symptom severity and ancillary symptoms that are related to, but not part of, formal diagnostic criteria
- The SADS has been used in justice settings to diagnose mental disorders (Blackburn & Coid, 1998; Hodgins, Lapalme, & Toupin, 1999) and has been found to be effective in these settings (Rogers, Sewell, Ustad, Reinhardt, & Edwards, 1995; Rogers, Jackson, Salekin, & Neumann, 2003)
- The SADS is useful in inpatient, outpatient, and primary health care settings for diagnosing CODs and providing referral to services (Rogers, Jackson & Cashel, 2004)
- The SADS has adequate concurrent validity for mental disorders when compared with other diagnostic interview instruments (Farmer et al., 1993; Rogers et al., 2004; Hesselbrock, Stabenau, Hesselbrock, Mirkin, & Meyer, 1982)
- The SADS-C has good reliability in diagnosing mental disorders (McDonald-Scott & Endicott, 1984)
- The SADS-C subscales of schizophrenia, depression, and bipolar disorder are significantly correlated with similar scales on the Referral Decision Scale (Rogers, Sewell et al., 1995), and other studies provide evidence of concurrent validity of the SADS-C (Johnson, Magaro, & Stern, 1986)
- Within justice settings, the SADS-C shows good interrater reliability for symptoms and subscales (ICC = .92, range .94–.97; Rogers et al., 2003) in both treatment seeking and emergency care settings
- Across multiple studies, the SADS exhibits good interrater reliability for symptom ratings and diagnosis (Andreasen et al., 1982; Endicott, & Spitzer, 1978; Keller et al., 1981; Rogers, Sewell et al., 1995)
- The SADS's test-retest reliability is moderate to high (McDonald-Scott & Endicott, 1984; Rapp, Parisi, Walsh, & Wallace,1988) when the elapsed time between administrations is less than 6 months

Concerns

- The SADS was developed concurrently with the DSM-III and does not use DSM-IV or DSM-5 terminology or classification systems
- There is poor agreement between the SADS and the DIS in diagnosing depression among individuals with substance use problems (Hasin & Grant, 1987)
- The SADS does not adequately address all substance use disorders, and thus, other interviews such as SCID may be preferred (Rogers, 2001)
- The SADS has not been used extensively in justice settings
- The SADS is rather lengthy and complex to administer and requires clinical judgment
- Significant training is required for administration and scoring of the SADS
- The instrument is not very sensitive to response styles, and participants can fake positive symptoms of disorders. Research has examined the potential use of some SADS-C subscales to detect malingering (Rogers et al., 2003)

- The SADS provides limited breadth of coverage, with a focus on evidence of

- The SCID has been used to assess CODs, including treatment-seeking individuals who have substance use disorders (Kidorf et al., 2004)
- In a community sample, the SCID for Axis II disorders shows adequate interrater reliability for diagnoses (kappas range .85–.95) in addition to adequate agreement for the presence of individual traits related to mental disorders (ICCs range .87–.99). The self-report SCID-II demonstrates good interrater reliability for the diagnosis of the personality disorders (kappas range .66–.99; Farmer & Chapman, 2002)
- Peters et al. (1998) examined the use of the SCID among correctional populations using DSM-IV guidelines. Kappas were moderately high for alcohol disorders (current diagnosis, .80; lifetime diagnosis, .78) and varied considerably for drug use disorders (current diagnosis, .48–1.00; lifetime diagnosis, .04–1.00), although these were generally quite high
- The SCID shows good interrater reliability in people receiving outpatient treatment across mental disorders (Zimmerman & Mattia, 1999a) and for both lifetime and past month alcohol and drug disorders among offenders (Peters et al., 2000)
- The internal consistency of the SCID-II is good, with alphas ranging .71–.94 (Maffei et al., 1997)

Concerns

- The SCID was designed for use by a trained clinician at the masters or doctoral level, although in research settings, it has also been used by bachelors-level technicians with extensive training. Significant training is required for both administration and scoring of the SCID
- Administration of the SCID I and II may each require more than 2 hours for individuals who have multiple diagnoses. The Psychoactive Substance Use Disorders module requires 30–60 minutes, when administered separately
- For people with cognitive impairment or psychotic symptoms, the SCID may need to be administered across several sessions
- Clinical judgment is required to determine whether symptoms are present for a particular disorder
- An eighth-grade reading level is required for the SCID
- The SCID provides a dichotomous decision (yes/no) regarding diagnoses, and it does not provide subthreshold diagnoses or take into account symptoms that may be experienced along a continuum
- The SCID is quite costly to purchase

Availability and Cost

The SCID is available for purchase from American Psychiatric Publishing, Inc., 1400 Street, N.W., Washington, DC 20005, at the following site: http://www.appi.org/home/search-results?FindMeThis=SCID

Available materials include SCID user's guides, administration booklets, and score sheets. The Research Version of the SCID can be obtained by contacting Biometrics Research at (212) 960-5524.

The user's guide and administration booklet cost approximately $80 for either the SCID-I or SCID-II. A packet of SCID score sheets costs approximately $80.

The SCID-5 products can be purchased at the following site: https://www.appi.org/products/structured-clinical-interview-for-dsm-5-scid-5

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within justice settings. Although summaries of instruments are based on DSM-IV criteria, instruments recommendations are those that align more closely with DSM-5, allowing for a more seamless transition from DSM-IV to DSM-5. Recommendations for assessment and diagnosis of co-occurring mental and substance use disorders include instruments that provide comprehensive examination of multiple disorders and related biopsychosocial problems. The following instruments are recommended:

1. TheAlcohol Use Disorders and Associated Disabilities Interview (AUDADIS-IV), which provides a comprehensive assessment and examines a range of co-occurring substance use and mental health problems, including personality disorders and psychosocial risk factors.

(or)

2. The Mini International Neuropsychiatric Interview (MINI) or the Structured Clinical Interview (SCID), which address a full range of co-occurring mental health and substance use disorders and provide a diagnostic impression of multiple disorders.

Each instrument requires between 45-120 minutes to administer, dependent on the symptom presentation and particular problems that are selected for assessment. The measures can E H D G P L Q L V W H U H G L Q W K H L U H Q W L modules can be administered that are tailored to the individual's assessment needs and set of symptoms. The different options provided here for assessment and diagnosis of co-occurring disorders may be appealing dependent on the V S H F L ¿ F Q H H G V L Q D S D U W L F X O D U MINI and SCID provide diagnosis of the full set of disorders, while the AUDADIS provides a comprehensive assessment of the disorders and a review of related biopsychosocial problems. These instruments should be administered by W U D L Q H G F O L Q L F L D Q V Z K R D U H O L otherwise credentialed in assessing and diagnosing CODs and related psychosocial problems.

Suggested Reading

Improving Cultural Competence: Treatment Improvement Protocol Series No. 59

Source: Substance Abuse and Mental Health Services Administration

Availability: http://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA14-4849

Description: Assists professional care practitioners and administrators in understanding the role of culture in the delivery of substance use and mental health services. Discusses racial, ethnic, and

Trauma-Informed Care in Behavioral Health Services: Treatment Improvement Protocol Series No. 57

Source: Substance Abuse and Mental Health Services Administration

Availability: http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

Description: Assists behavioral health professionals in understanding the impact and consequences for those who experience trauma. Discusses patient assessment, treatment planning strategies that support recovery, and building a trauma-informed care workforce. Chapter 4 addresses screening and assessment.

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